Men and Reproductive Health

"The objective is to promote gender equality in all spheres of life…and to encourage and enable men to take responsibility for their sexual and reproductive behaviour and their social and family roles." —*Conference on Population and Development, Cairo, 1994.*

In recent years, many family planning and other reproductive health programs have become interested in the topic of men and reproductive health (which is sometimes called "male involvement" or "men as partners").

These programs recognize that men have an important influence on women's and children's health and also have distinct reproductive health needs of their own. In many cultures, men also may serve as gatekeepers to women's access to reproductive health services. Research and program experience are demonstrating that many men care about and are willing to make positive contributions to

the reproductive health of their partners and well-being of their families. Despite the surge of interest in this area, there is a lack of consensus about what it means to involve men in reproductive health programs and uncertainty about how such involvement will affect women's health and status.

Use this site to view information about the evolution of thinking regarding men and reproductive health, summaries of research on various ways that men can have a positive influence on women's health, information about men's reproductive health concerns, links to related sites, and examples of various approaches that are being used to include men in the quest for improved reproductive health.

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Introduction

Historically, most reproductive health programs focused on family planning and in turn most family planning programs offered their services exclusively to women. Most viewed women as the "target group" and paid little attention to the roles that men might have with respect to women's reproductive health decision-making and behavior. A few programs made attempts to address men's needs for information and services, with these efforts mainly focused on encouraging men to use family planning methods (such as condoms and vasectomy) or to become more active in the couple's decision-making about contraceptive use. Some programs also provided sexually transmitted infection (STI) treatments to men.

In the 1990s, many women's health programs began to acknowledge that family planning must be viewed in the broader context of reproductive health. The epidemic lead providers to consider social, economic, and cultural factors—including gender inequity—as significant to women's overall health status. The AIDS epidemic forced women's health programs that focused primarily on family planning to broaden the scope of their services and include STI/HIV prevention. As part of this broader view, programs started to focus on the role of men as it relates to women's access to and use of reproductive health services. For instance, the 1994 International Conference on Population and Development in Cairo Program of Action includes a statement on "Male Responsibilities and Participation" (www.iisd.ca/linkages/Cairo/program/p04000.html):

"Special efforts should be made to emphasize men's shared responsibility and promote their active involvement in responsible parenthood, sexual and reproductive behavior, including family planning; prenatal, maternal and child health; prevention of STDs, including HIV; prevention of unwanted and high-risk pregnancies; shared control and

contribution to family income, children's education, health and nutrition; and recognition and promotion of the equal value of children of both sexes."

The same message was reinforced at the 1995 World Conference on Women in Beijing (www.un.org/womenwatch/daw/beijing/platform):

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

Discussions about women, men, and reproductive health also included recognition that gender inequalities between women and men have a significant influence on sexual health. Gender inequalities exist in the labor force, the legal system, government posts, the community, the home, and the bedroom; all of these ultimately affect women's health and well-being. These issues are discussed more fully in RHO's Gender and Sexual Health section.

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Men and reproductive health: goals, concerns, and questions

Today, reproductive health professionals are working to form a consensus around the issue of men and reproductive health, and many agencies involve men in their programs. Many—such as the Interagency Gender Working Group Subcommittee on Men and Reproductive Health—believe that efforts to involve men should adhere to the following core goals:

I. Promoting women's equal status in reproductive health decision-making in the context of gender equity.

II. Increasing men's support of women's sexual and reproductive health and of children's well-being, with equal regard for female and male children.

III. Meeting the reproductive and sexual health needs of men (in addition to those of women).

For specific examples of program activities that address these goals, see Programming Approaches to Men and Reproductive Health.

Intertwined with the discussion of guiding goals for programs addressing men and reproductive health are a number of concerns and questions regarding "best practices" and potential outcomes of such programs (Berer 1996; Helzner 1996; de Schutter,1999). Foremost among these is the issue of whether involving men in family planning education and services could further erode women's control over reproductive health decisions. Many view reproductive health services as a tool women can use to claim a degree of autonomy in their lives. Providing women with access to such services has been a hard-fought battle, which most would argue is far from over. Some fear that encouraging men to participate will result in perpetuating existing gender inequalities, particularly with respect to communication and sexual decision-making. For example, a "male motivation" campaign in Zimbabwe used masculine sports figures to encourage men to play a greater role in family planning decision-making with their partners. One unexpected result of the campaign was an increase in the percentage of men who thought that they should have sole control over contraceptive decision-making. Involving men in other aspects of reproductive care, such as abortion counseling, could have similar negative consequences.

A related concern is whether programs designed to involve men as partners in reproductive health will compete for

funding with programs designed to improve women's health (de Schutter,1999). Some have argued that limited resources should not be allocated to men's reproductive health when the status of women's health still lags far behind that of men. Yet, many of those who include men in their service delivery programs see this as something that is mutually beneficial and therefore a good investment in women's health.

Another key question facing programs is how best to involve men. Given that most reproductive health programs have focused on women, few models for the inclusion of men exist. In addition, those that exist are typically small pilot projects and many have not been well evaluated with respect to their impact on women or men or cost-effectiveness. Programs must also find ways to overcome specific challenges or barriers related to men, including:

- lack of information about men's perspectives that could be used to help design appropriate programs;
- men's discomfort; because they have been excluded from services for so long, many men feel out of place or unwelcome at reproductive health clinics;
- men's hesitance to seek medical care;
- limited availability of contraceptive methods for men;
- negative attitudes of policy makers and service providers toward men; for example, viewing men as irresponsible, not interested in playing a positive role, or not an appropriate clientele for reproductive health services;
- unfavorable policies, such as prohibitions on condom advertising;
- logistic constraints, such as lack of trained male staff, male-friendly clinics, convenient hours, or separate waiting and service areas for men.

Despite these concerns and challenges, there are ways in which well planned programs could positively contribute to women's and men's reproductive health and to normative change around gender issues. The challenge is to ensure that the activities undertaken are supportive of women and that the program itself does not contribute to worsening inequalities between women and men.

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Men's role in women's and children's health

The ways in which men influence women's health are numerous (Foumbi and Lovich 1997). As husbands, boyfriends, fathers, brothers, and friends, men can have a positive effect on women's health by:

- using or supporting the use of contraception such that sexual partners are able to control the number and timing of pregnancies;
- encouraging women to have adequate nutrition during pregnancy and providing the needed physical, financial, and emotional support to do so;
- supporting women during pregnancy, delivery, and the postpartum period;
- supporting the physical and emotional needs of postabortion women;
- preventing the spread of STIs to their partners;
- preventing all forms of violence against women;
- working to end harmful health practices, such as female genital mutilation (see RHO's Harmful Health Practices section;
- sharing financial resources with women, including support for shared property rights;
- supporting women's full participation in civil society, including access to social, political, and educational opportunities, many of which have a direct or indirect impact on women's health;
- supporting daughters' rights to health care, education, and respect in equity with sons.

Men who are more involved in the health of their families also may enjoy better health and closer relationships with

family members (Greene 1999).

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Men's reproductive health concerns

Like women, men have reproductive health concerns that change as they move through their life cycles. As programs begin to reach out to men as partners in ensuring good reproductive health, they will need to understand these evolving needs as well as other factors influencing men's sexual behavior, goals, and perceptions.

Boys are affected by cultural and medical practices related to reproductive health as soon as they are born. For example, in some regions infant boys are routinely circumcised (in other regions, circumcision is performed when a boy reaches adolescence or not at all); research from developing countries has shown that male circumcision reduces the risk of HIV-infection by at least 50 percent (Best 1998). (See the discussion of male circumcision and HIV in RHO's HIV/AIDS Key Issues for more information.)

As boys reach puberty, they experience significant physical changes, including changes in their voice patterns, growth of pubic and body hair, and increased development of muscle tissue. These physical changes are often accompanied by new emotions and behaviors, including the development of sexual feelings, experimentation with sexual encounters, and questions about sexual issues, such as penis size, sexual orientation, and masturbation (Centerwall 1995). A boy's experience of and response to these changes is shaped to a large degree by the gender roles and expectations prevalent in his culture. Boys also may be vulnerable to sexual abuse. For more information, see Reaching adolescent males on the Key Issues page.

As young men become more sexually active, their concerns are similar to those of many young women and include sexuality, intimate relationships, peer norms, and prevention of unintended pregnancy and sexually transmitted infections. These issues may affect men and women at different times in their reproductive lives and to different degrees, however. For example, men do not suffer the serious and sometimes deadly consequences of pregnancy, childbirth, and unsafe abortion. Nevertheless, men in unions may share many of the same concerns as women about family planning, including how to prevent pregnancy, how to make decisions related to the number and spacing of their children, whether contraception is safe, and how to select and use an effective contraceptive. Preventing and treating sexually transmitted infections, including HIV/AIDS, also is a key health concern of sexually active men (see RHO's Reproductive Tract Infections section). Many men also are concerned about infertility, especially given the high prevalence of STIs in some areas and concerns that some male infertility may be linked to environmental or occupational exposures (see RHO's Infertility section).

As men grow older, concerns about impotence and other forms of sexual dysfunction may become more common (though these concerns may be prevalent among younger men as well). In addition, cancers of the reproductive tract, especially prostate cancer, become more prevalent as men age, though rates of male reproductive cancers are low compared with those affecting women. Other issues, such as urinary tract conditions, also can contribute to discomfort or inability to function normally as men grow older.

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Designing programs that include men

Various strategies have been used to engage men as partners in improving women's reproductive health and to extend reproductive health services to men. Most of the projects conducted to date have focused on including men in

reproductive health services rather than on the ultimate goal of achieving gender equality through normative change. Approaches have included

- adding services for men to existing clinic-based services or establishing separate services:
- reaching men through the workplace, military, or men's groups with information and services;
- condom social marketing;
- community-based distribution of contraception using male field workers;
- outreach to male youth;
- mass-media educational campaigns;
- special initiatives, such as outreach through popular sporting events.

Most of these projects have been small in scale and little information is available about how these activities have influenced the complex relationships between women and men and their health.

Given the strong influence that gender inequality plays in reproductive health status, some have argued that designing "male involvement" or "men and reproductive health" programs is an inadequate approach (Helzner 1996). Instead, programs need to look at the needs and perspectives of both men and women, to ensure that the equality of genders is considered. In designing activities, it will be important for programs to:

- identify the needs and perceptions of both men and women;
- use gender analysis as a tool to examine the gender implications of proposed activities;
- evaluate the impact of activities using gender-related indicators (Yinger and Murphy 1999).

For examples of possible approaches to address the three core goals of men and reproductive health programs—increasing gender equality through normative change, increasing men's support of women's and children's health, and addressing men's own health needs, see Programming Approaches to Men and Reproductive Health.

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Programming Approaches to Men and Reproductive Health

Goal I: Promoting women's equal status in reproductive health decision-making in the context of gender equity.

Broad categories of programming: community mobilization; education on gender equity for men, women, and children; and communication for normative change (mass media, policy work).

Specific types of activities:

- information, education, and communication (IEC) approaches to policy makers to promote the health benefits of reproductive rights and gender equity;
- IEC to the general public to promote the health benefits of reproductive rights and gender equity;
- anti-violence campaigns, including research (if needed); work with hospitals/police/courts to identify and help victims and to enforce anti-violence laws; and community-based activities to address root causes of violence;
- community-based activities to examine and modify men's goals concerning models of masculinity, human rights, and gender norms;
- modules for school-based youth and special events to examine and modify gender roles with a focus on responsibility and gentleness as central aspects of what it means to be a man.

Goal II: Increasing men's support of women's sexual and reproductive health and of children's well-being, with equal regard for female and male children.

Broad categories of programming: couple and individual counseling (for men and women), as appropriate; outreach, especially to youth; reproductive health education in schools and for out-of-school youth.

Specific types of activities:

- as part of training for providers on client-provider interactions, including components on reproductive/sexual rights, fostering couple communication, and counseling of couples;

- outreach to include partners in postabortion care and counseling (if the woman wants it);
- in community-based education, including sessions specifically for men (or which include men) about the danger signs of pregnancy/delivery and how to address them (e.g., development of emergency transportation plans), childhood nutrition and illness management, and child abuse prevention;
- youth peer counseling and education programs;
- including images of men as supportive partners in a wide range of IEC materials;
- informing men and women of the potential consequences of men's behavior on women's health.

Goal III: Meeting the reproductive and sexual health needs of men (in addition to those of women).

Broad categories of programming: demand creation (IEC about available services), service improvements, provider training, organizational commitment and objectives.

Specific types of activities:

- community-based reproductive health education and services, including working with local non-governmental organizations to add a men's component to existing programs; factory-based gender and reproductive health information programs and contraceptive distribution; or adding reproductive health modules in community-based training/educational activities often aimed at men (e.g., agriculture extension);
- mass media activities, including talk shows, TV/radio spots, comic books, topical columns in newspapers, dramas/soap operas, billboards;
- family life education programs for boys and girls;
- training providers to focus on the special needs of men;
- offering services at sites and times well suited to male clients;
- developing safe places for homosexual or bisexual youth and men to discuss their concerns about reproductive health and homophobia (e.g., violence);
- improving the quality and accessibility of vasectomy services through provider training and IEC;
- social marketing of condoms;
- providing high-quality, discreet STI/HIV services to men;
- additional research on contraceptive methods men can use.

(Adapted from Yinger and Murphy 1999.)

Key Issues

This section provides summaries of emerging research and program issues in men and reproductive health that are relevant to the developing world.

- Men's influence on women's health
- Impact of couple counseling
- Impact of gender role expectations on men's health
- Men's reproductive health needs and concerns
- Reaching adolescent males
- Men and HIV
- Dual protection
- Gender-based violence
- Outcomes of "men and reproductive health" programs
- Men's attitudes toward family planning
- Vasectomy and cancer
- Contraceptive methods for men

Be sure to use the Glossary if you are unfamiliar with any of the terms on this page**.**

Men's influence on women's health

Involving men in reproductive health has been found to have a positive impact on women's and children's health in a number of ways, including improving MCH care, preventing or reducing STI/HIV/AIDS transmission, and improving contraceptive use-effectiveness and continuation. A study on the impact of providing antenatal education to prospective fathers in India found a significantly higher frequency of antenatal clinic visits and significantly lower perinatal mortality among the women whose husbands received antenatal education (Bhalerao et al. 1984). Furthermore, men participating in antenatal education tend to know more about family planning methods and are more concerned about their partner's

nutritional needs during pregnancy (Raju and Leonard, ed. 2000). A study in Egypt has found that husbands who received counseling at the time of their wives' abortions were more likely to be supportive during the recovery period (Abdel Tawab et al. 1997). Enlisting men in the fight against STI/HIV/AIDS is particularly important given that men frequently transmit STIs to their monogamous partners. Research has shown that married women's greatest risk factor for STIs is the sexual behavior of their husbands (Hunter et al. 1994; Foreman 1999). Men are much more likely (eight times) to transmit HIV to women through repeated acts of unprotected sexual intercourse than vice versa (Padian et al. 1997).

Studies have shown that involving men can increase contraceptive adoption, client satisfaction, contraceptive use-effectiveness, and contraceptive continuation. Randomized trials have found that contraceptive adoption was significantly higher among women whose husbands were included in contraceptive counseling compared to women whose husbands were not involved (Fisek et al. 1978; Terefe et al. 1993). A recent randomized study in China has demonstrated improvement in contraceptive use-effectiveness for couples when the husband was involved in contraceptive counseling (Wang et al. 1998). Several studies have shown higher contraceptive continuation among clients whose husbands have been involved in contraceptive counseling. A study in Madagascar found that women were more likely to continue using Norplant implants if their husbands had been involved in the counseling process (Tapsoba et al. 1993).

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Impact of couple counseling

Increasingly, reproductive health interventions focus on couples rather than on the individual. A review of studies of reproductive health interventions concluded that in most instances a "couple approach" can be more successful than serving individuals (Becker 1996). Improving communication between partners on sexual and fertility-related matters appears to improve contraception use (Salway 1994) but is not necessarily a prerequisite for men's involvement in family planning use (Karra et al. 1997). Even in areas in which the prevailing culture emphasizes men's authority over women, many couples report discussing matters related to family size and contraceptive use (Renne 1993). Programs that use a couple approach must be carefully designed so as not to jeopardize a woman's decision-making and self-determination when they do not agree with their male partner (Becker and Robinson 1998).

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Impact of gender role expectations on men's health

While discussions of gender issues rightly focus on the serious and negative impact of gender inequities on women (see RHO's Gender and Sexual Health section), gender role expectations prevalent in many societies also affect men. For instance, in many cultures concepts of masculinity may be tied to a man's ability to provide economic support and protection for his family. As it becomes harder and harder for men to fill this role successfully, some men may turn to alternative measures, such as violence, to maintain authority in the family (Barker 1997). Gender role expectations also may make men feel constrained from expressing their dedication to their wives or from participating in the care and nurturing of children or in household management, lest they risk ridicule from friends and neighbors. Societal expectations for men also can lead to threatening situations for the men themselves, such as when homosexual men are subjected to harassment or physical abuse because their sexual orientation differs from the norm.

In addition, in some countries, male gender roles may encourage risk-taking and discourage men from using health care services of any kind, much less reproductive health care services (Rappaport 1984; Moynihan 1998). This is illustrated by cultural expectations for young men to resolve disputes with other men through violence and to prove their manliness by taking risks, such as reckless driving of cars and motorcycles. As a result, there are large differences between young men and women in age-specific death rates due to violence and accidents (Rappaport 1984). Others have suggested that this

type of risk-taking behavior also extends to reproductive health risks, such as having sex without condoms (Foreman 1999). For instance, some young men in Kenya glorify acquiring an STI as a badge that confirms manhood (Nzioka 2000). In some regions, men may have sex with men without recognizing this as a potentially risky activity. For instance, in the South Asia region, it is relatively common for men to engage in sexual play with other men, including boys and relatives (Khan 1998).

Gender stereotypes also can lead men to certain occupations or behaviors that affect their health. For instance, jobs that require seasonal migration or other travel (such as trucking) often are held by men. These jobs remove men from their home environment, resulting in less time with their spouses and families, infrequent opportunities for spousal sexual relations, and increased opportunities for sex outside of marriage or with sex workers (Kootikuppala et al. 1999). In addition, some typically male occupations may affect fertility or overall reproductive health (Keleher 1991). (Also see RHO's Infertility section.) One study of taxi drivers in Italy found that drivers had a significantly lower prevalence of normal sperm compared with controls (Figa-Talamanca et al. 1996). A study of 46 papaya workers in Hawaii found that long term exposure to ethylene dibromide, a common pesticide, resulted in significant decreases in sperm count and percentage of viable and motile sperm and increases in the proportion of sperm with abnormalities compared with non-exposed men (Ratcliffe et al. 1987).

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Men's reproductive health needs and concerns

Men have varied reproductive health concerns. For instance, a study of men's perceptions of sexual problems in a Mumbai slum community found that men were most concerned with sexual weakness, itching around genital areas, burning sensation during urination, early ejaculation, wounds on the genitals, and white discharge (Ravi et al. 1999). Issues raised by men in Pune, India, include masturbation, consequences of loss of semen, menstruation, pregnancy, and AIDS (Raju and Leonard 2000). A study in Bangladesh of 622 men attending a special "men's clinic" found that the most common complaints were pain passing urine (42%); psychosexual problems such as impotence, premature ejaculation, and sexual dissatisfaction (42%); urethral discharge (38%); and non-reproductive health complaints, such as cough or weakness (18%). A survey of 969 men in the general population of the clinic area found that 17 percent reported psychosexual problems (Hawkes 1998). The pain and discharge reported by these men are likely symptoms of sexually transmitted infections, which may be common among some populations of men. For instance, a study of 137 men attending an urban STI clinic in Mongolia found that 31 percent, 8 percent, and 9 percent were infected with gonorrhea, chlamydia, and syphilis, respectively. In addition, 20 percent of the men had nongonococcal urethritis (Schwebke et al. 1998).

Older men participating in focus groups in Australia identified urinary symptoms, prostate cancer, and sexual function as key concerns. Urinary symptoms were particularly problematic for men whose occupations limited their access to toilets, such as taxi drivers, truckers, or traffic controllers (Pinnock et al. 1998). Research on the extent of sexual dysfunction also is limited, particularly outside the United States (Bortolotti et al. 1997). Incidence increases with age (one large study reported rates of minimal, moderate, or complete impotence in approximately 40 percent of 40 year olds, increasing to 66 percent among 70 year olds) and also may be exacerbated by factors such as smoking, alcoholism, certain chronic diseases, and certain medications.

Some men want more than just information about their own health issues. For example, men participating in focus groups in Colombia also wanted to know how to communicate with children and partners as well as foster new ideas about being gender-sensitive in a changing society (Eshcen et al. 1999).

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Reaching adolescent males

Young men may be a particularly important audience for "men and reproductive health" programs because they often lack access to health information and services and may be more open to considering new ideas than their older counterparts. The Interagency Gender Working Group (IGWG) Subcommittee on Men and Reproductive Health chose working with adolescent males as one of its three priorities; click here to see their theme statement on adolescent males.

Review of patient records from a New York City clinic serving primarily young, Dominican men found that most had been sexually active for several years before their first visit. In addition, while the majority initially sought services for routine medical services, such as a sports exam or physical, more than a quarter of these patients were also treated for an STI. This highlights the value of offering a full spectrum of health services as a way of drawing men into a program (Armstrong 1999).

Promoting gender equity during adolescence may be more effective than later on in life; evidence suggests that young men frequently are more willing than adult men to consider alternative views about their roles in reproductive health. For instance, research among young men in Colombia found that adolescent males showed a greater interest in and desire to communicate more with women and recognize women's right to decision making (Eschen et al. 1999).

Socialization plays a key role in influencing men’s behavior. Although biological differences between boys and girls impact their health and development, the World Health Organization’s Department of Child and Adolescent Health (CAH) found that differences in gender socialization have a greater effect (WHO 2000). Thus, identifying socialization factors that shape more gender-equitable boys has implications for more effective program design. Please see **Table 1** for more information about promoting gender-equitable versions of masculinity. Also see RHO's Adolescent Reproductive Health section for more information about adolescent issues.

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Men and HIV

Statistics clearly indicate that men play a critical role in spreading AIDS. Furthermore, men's attitudes about sexuality and sense of invulnerability put women and men at risk (Barker 2000; Foreman 1999). Men are likely to have more sexual partners than women, thus men are at greater risk of becoming infected and transmitting the virus. Drug use is attributed to approximately 10 percent of the world's cases of HIV transmission; 80 percent of these cases involve men (Barker 2000).

Research and pilot projects are helping to fine-tune successful strategies and identify essential elements to involve men in HIV/AIDS prevention and treatment. Important program considerations include:

- Developing frameworks that place men alongside women in the global response to HIV and AIDS (Aggleton 2000).
- Finding more gender-equitable forms of socialization.
- Breaking the silence and stigma associated with HIV/AIDS, including men having sex with men and substance abuse.
- Providing men with the space and security to talk about sexuality.
- Finding ways to encourage men to take care of themselves, their partners, and their families (Aggleton 2000; Barker 2000; Foreman 2000; Raju and Leonard 2000).

Literature about men and HIV is expanding rapidly. The Panos Institute recently became an official partner of UNAIDS for the 2001 World AIDS Campaign. As part of this effort, the institute created four documents on men and HIV in Zambia, Malawi, Zimbabwe, and Swaziland that are available on the Panos Institute website.

For more information about HIV/AIDS, please see RHO's HIV/AIDS section. For information about male circumcision in relation to HIV/AIDS, please see RHO's HIV/AIDS Key Issue on male circumcision and HIV and the Special Report from the September 2002 Male Circumcision Conference.

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Dual protection

Dual protection is defined as protection from pregnancy and STIs/HIV either through the use of a condom alone or the use of a condom plus another contraceptive method. Abstinence, or avoidance of penetrative sex, is another means of achieving dual protection (Spieler 2000). Dual protection is one of three priority areas of the IGWG Subcommittee on Men and Reproductive Health (also see the IGWG statement on dual protection).

To date, dual protection promotion in clinics is rare, difficult to achieve, and a sensitive issue to discuss. Important considerations in dual protection programs are people's reproductive intentions, STI risks, and cultural norms such as gender inequity (Cates et al.; Marcham et al. 1999; Nzioka 2000). Barriers to condom use need to be acknowledged and addressed. For instance, some women may face violent reactions from their husbands if they suggest using condoms (Stanback 2000).

For more information about condoms and other family planning methods, please see RHO's Contraceptive Methods section.

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Gender-based violence

Gender-based violence, as defined by the United Nations General Assembly, includes all acts or threats of violence that result in, or are likely to result in, physical, sexual, or psychological harm and/or suffering to women. Gender-based violence is another priority theme of the IGWG Subcommittee on Men and Reproductive Health; click here to see their theme statement on gender-based violence. The most common forms of violence against women are abuse and coerced sex that can occur in childhood, adolescence, or adulthood (Heise et al. 1999). Female genital mutilation (FGM) comes under the rubric of gender-based violence.

According to the World Bank, the health burden "from gender victimization among women aged 15 to 44 is comparable to that posed by other risk factors and diseases, including HIV tuberculosis, sepsis during childbirth, cancer and cardiovascular disease" (Heise et al. 1999).

Recent studies attribute men's propensity to violence to "men's contradictory experiences of power" as follows:

a. the impossibility of meeting the multiple demands of manhood and the use of violence as a compensatory mechanism;
b. the psychological armoring, which keeps some men who commit violence from being in touch with the feelings

and the pain of those around them and of their own pain;

c. the crippling prohibition of the expression of a range of emotions by men in most cultures, which buries feelings such as hurt, terror, and fear, and channels them into forms of emotional expression that are permitted: anger and aggression, which can flare up as violence;
d. past experiences as witnesses to violence against their mothers, experiences witnessing violence against others, and experiences as boys or young men in which violence was directed against them (Kaufman 2000).

Strategies to work with men on addressing violence encourage men to reflect on their lifestyles, the costs of their violence and the possible gains from being more caring and affectionate (AVSC and IPPF/WHR 1998).

For more information about gender-based violence, see the Violence against women discussions in RHO's Gender & Sexual Health Overview and Key Topics areas.

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Outcomes of "men and reproductive health" programs

While large-scale, long-term programs addressing men's various roles in reproductive health are lacking, there are numerous small, pilot programs across the globe that address issues such as family planning, sexually transmitted infection prevention, men's roles in families, and issues of gender equity, among other topics. The response from men to these programs has been overwhelmingly positive, with most men welcoming the opportunity to participate in and improve the health of their families.

Numerous regional conferences involving policy makers, program managers, and researchers as well as comprehensive reviews of programs addressing men have resulted in summaries of lessons learned and suggested strategies for the most effective approaches to reach men (Robey et. al. 1998; Liow et al. 1996; Danforth and Green 1997; Green et al. 1995; Healthlink Worldwide 1998; Drennan 1998; Johns Hopkins CCP 1997; FOCUS 1998; IPPF/RHO and AVSC 1998; Wegner et al. 1998; Davidson 1998; HIM 1999; Yinger 1999). It is worth noting, however, that the emphasis of the majority of programs carried out to date has been on involving men in contraceptive use and decision-making in addition to extending other reproductive health services to men. As such, the results may not be applicable to newer initiatives that approach the issue from a gender equity perspective.

Experience to date suggests that effective men and reproductive health programs:

- add services for men without subtracting from ongoing services for women. This has been done by adapting existing services and by charging fees for the additional services provided for men;
- are carefully tailored to a specific subgroup of men. Men are not one homogeneous group. Their needs vary by age, culture, marital status, sexual orientation, and education;
- make an effort to involve men in the program design and implementation. For example, recruiting satisfied clients to attract other clients (AVSC 1997); involving women in program design and implementation also is important to ensure that the needs of both sexes are considered. While women are highly effective as service providers in programs for men, it is recognized that appropriately trained and motivated male staff can make a positive difference. In some instances, the social-cultural environment can influence men's discomfort in receiving services from a female health care worker (Nzioka 2000).
- with few exceptions, have integrated services for men within existing services rather than establishing independent services for men. For instance, existing clinical services can be altered to meet men's needs by offering separate hours for men, training staff in men's reproductive health needs, ensuring the availability of educational materials for men, and implementing other relatively simple changes. Further research is needed on whether this approach in any way compromises services for women;

- give service providers in-depth training in the technical and counseling skills needed to work with male clients and with couples;
- often do not follow a traditional, clinic-based model. They deliver services where men are: at their place of work, at home, or at recreational settings;
- are attentive to men's needs, such as their working hours, need for privacy, and need for respect and compassion;
- make a strong effort to involve the community from the beginning, especially community leaders and "gate-keepers" for the men whom the program wishes to reach;
- provide a wide range of services (e.g., family planning, STI prevention and treatment, cancer screening, sexual health counseling, and general physicals), which helps attract enough male clients to generate adequate fees for services;
- have a system in place for program monitoring and evaluation. This system should include indicators to measure the amount and quality of services and the impact of the program, with particular emphasis on the gender-related consequences of the program to both women and men.

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Men's attitudes toward family planning

Data on men's attitudes toward family planning have only recently been collected. Research suggests that in many regions men view family planning favorably and can have a strong influence on the use of contraception. For example, research in Kenya suggests that contraception is two to three times more likely to be used when husbands rather than wives want to cease childbearing (Dodoo 1998). Results from Demographic and Health Surveys in 17 different nations in Asia, North Africa, East Africa, and West Africa support the following overall conclusions:

- Men and women have similar reproductive preferences and attitudes toward family planning (with the exception of West African countries).
- Men are no more opposed to family planning than women.
- Men tend to identify reproduction as a female responsibility (*Population Reports* 1999).
- In many countries, men are as favorable to condom use as women.
- Men's approval for and intentions to use family planning methods are similar to women's (with the exception of West African countries) (Ezeh et al. 1996; Roudi and Ashford 1996).
- Some men are suspicious of family planning programs, believing they undermine men's power (Ndong and Finger 1998).

Results such as these are supported by qualitative studies. For example, a study of male involvement among five generations of a South Indian family found that men readily accepted condom use and vasectomy, even though they may not have liked some of the specific characteristics of the method (Karra 1997).

Additional research is needed on both men's and women's attitudes toward use of and decision-making regarding reproductive health care services, with particular emphasis on how differences between men and women affect women's equality in decision-making.

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Vasectomy and cancer

Research on the long-term effects of vasectomy is ongoing. Although some studies have suggested a possible link between vasectomy and prostate cancer (see *Outlook,* Volume 13, Number 1), two recent studies and one meta-analysis

have found no overall increased risk (Bernal-Delgado et al. 1998; Platz et al. 1997; Zhu et al. 1996). These findings support results of two earlier studies; the first found no association between vasectomy and any cancer (Rosenberg et al. 1994) and the second found no association between vasectomy and testicular cancer (Moller et al. 1994).

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Contraceptive methods for men

Five currently available contraceptive methods are designed for use by men or require men's active participation—condoms, female condoms, vasectomy, natural family planning (NFP), and withdrawal. Each of these methods has unique advantages that may be attractive to some family planning clients. For instance, male and female condoms protect against sexually transmitted infections, vasectomy is safe and highly effective (in addition to being less expensive than female sterilization), and NFP and withdrawal are hormone-free and readily available at no cost to the user. These last two methods also promote communication and cooperation between partners. Despite these advantages, none of these methods is perfect, and many men and women would welcome the arrival of new contraceptives that men could use. Furthermore, the male condom is the only male contraceptive method that effectively protects against STIs and HIV.

Research continues on both permanent and reversible methods for men, though most methods under development will require at least 10 more years of research and testing before they are ready for introduction (Best 1998; AVSC/RHAE 1999). Types of methods being investigated include:

- injections, implants, and pills that provide hormones to alter men's fertility (Waites 1997; (CONRAD 1999); BBC 1999);
- methods that block the vas deferens (Lissner 1994);
- methods that use heat to inactivate spermatozoa (Lissner 1994);
- non-hormonal systemic methods (CONRAD 1998; Cohen 1996);
- improvements in existing barrier methods (CONRAD 1999).

For more information about contraceptives, see RHO's Contraceptive Methods section.

Table 1. Guidelines for Promoting Gender Equity

Research among lower income youth in Rio de Janiero, Brazil, has identified the following ways that youth-serving organizations can promote more gender-equitable versions of masculinity:**.**

• Offer individual spaces and group spaces for young men.
• Create spaces where young men feel comfortable questioning the costs of traditional versions of masculinities.
• Work with young men on reflecting about, writing, recording, valuing life histories.
• Offer adolescent males opportunities to be mentored and to mentor.
• Encourage reflection and discussion about the current state of affairs in male-female relationships and conflict-resolution in dating relationships.
• Promote discussions about fatherhood and the meaning of fathers.
• Provide connections to spaces where young men can learn new skills, both vocational and domestic.

Annotated Bibliography

The entries below are organized under the major research areas used in the Key Issues section.

Page 1:	General Men's influence on women's health Impact of couple counseling Impact of gender role expectations on men's health
Page 2:	Reaching adolescent males Men's reproductive health needs and concerns Outcomes of "men and reproductive health" programs Men and HIV
Page 3:	Dual protection Gender-based violence Men's attitudes toward family planning Vasectomy and cancer New contraceptives for men

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RHO : Topics : Men and Reproductive Health

Annotated Bibliography

This is **page 1** of the Men and Reproductive Health Annotated Bibliography. This page contains:

- General
- Men's influence on women's health
- Impact of couple counseling
- Impact of gender role expectations on men's health

To access more bibliographic entries, visit page 2 or page 3, or return to the complete list of topics covered in the Men and Reproductive Health Annotated Bibliography. Be sure to use the Glossary if you are unfamiliar with any of the terms on this page.

Please note that PDF files require Adobe Acrobat Reader software, which can be downloaded for free at www.adobe.com/products/acrobat/readstep.html.

General

AVSC (now EngenderHealth). ***Men as Partners in Reproductive Health: Workshop Report***. Mombasa, Kenya (1997). This report on an inter-regional workshop on men's involvement in reproductive health addresses gender issues and provides a blueprint for creating male reproductive health programs. It includes a section on how to overcome common obstacles, proposes communication strategies, and provides examples of existing services and information on supportive donors.

AVSC (now EngenderHealth) and IPPF/WHR. ***Male Participation in Sexual and Reproductive Health: New Paradigms Symposium.*** Oaxaca, Mexico (1998). Summary of the symposium available at: www.engenderhealth.org/ia/wwm/emwksp1.html. The full report can be ordered at no charge at: www.ippfwhr.org/publications/publication_detail_e.asp?PubID=19l.

One of the outcomes of the symposium was the production of three papers—a Symposium Report, a Literature Review and Five Case Studies—which are summarized below:

- ***Symposium Report.*** This report captures the main themes discussed at this meeting of service providers, policy makers, program directors, and donors from countries throughout the Americas. The topics include masculinities, sexualities, prevention of STIs, violence, and fatherhood. This report provides a comprehensive overview of research and program approaches to involve men in sexual and reproductive health in the Americas between 1995 and 1998. It also identifies program and research priorities.
- ***Literature Review.*** This review includes literature on men and reproductive health themes written between 1990 and 1998. Several pages are devoted to adolescent sexuality. The socialization of boys is addressed under "masculinity/ies." Gender and masculinity, sexuality, STIs, HIV and AIDS, masculinity and sexual and reproductive health, violence, and fatherhood are other topics included in the review. The publication contains abstracts of the papers reviewed.
- ***Five Case Studies.*** This document describes five programs in Latin America that involve men in sexual and reproductive health. These are MEXFAM's program to develop education materials that promote discussion about male involvement and Salud Y Género's participatory workshops on masculinity and male involvement in Mexico; CISTAC's work in Bolivia that explores masculinities and methodologies for working in male involvement; and the work of ECOS with men in the workplace in Brazil.

Clark, S., et al. ***Increased Participation of Men in Reproductive Health Programs.*** Report for the Royal Ministry of Foreign Affairs, Oslo, Norway (21 February 1999).
This study was commissioned to inform the ICPD+5 process on how to increase men's participation in reproductive health based on the progress and difficulties encountered since the ICPD (1994). It highlights examples of successful trends and promising program innovations as well as areas where progress is lacking. Examples of progress include greater availability of qualitative and representative quantitative data on men, greater use of condoms, and greater donor awareness and support for male participation in sexual and reproductive health. Examples of problems that are yet to be addressed include unanticipated negative impact of some initiatives, low turnout for male sexuality training, unsustained initiatives, lack of institutional memory, and lack of communication among programs. Unresolved issues include concerns about how to address gender in programs that want to encourage men's participation; how to address men's reproductive rights while consolidating and expanding the reproductive health rights of women; whether and how essential it is to serve male clients only by male providers; and how to balance the strategy of treating couples with the needs of individual women and men. The paper concludes with several recommendations for increasing men's participation, such as disseminating successful initiatives in Scandinavia and an extensive list of research activities. It advocates that the highest priority be given to programs for young men in developing countries. An analysis of regional findings is annexed to the report.

Figueroa, J.G. ***Some Reflections on the Presence of Males in the Reproductive Process.*** Based on presentations made at the Seminar of Studies on Masculinity, University Programme of Gender Studies, Autonomous National University of Mexico (Figueroa and Liendro) (1994) and at the Seminar on Fertility and the Male Life Cycle in the Era of Fertility Decline, IUSSP, Zacatecas, Mexico (1995).
This paper is a proposal that advocates for the development and adoption of new conceptual and operational frameworks as well as indicators for analysing reproduction, fertility and reproductive decision-making. It illustrates some of the theoretical and practical complexities that arise in integrating men into the reproductive processes. The author's thesis is that reproduction, in its broadest sense, includes gender organization, masculine and feminine identities, and the exercise of sexuality, factors that are ignored in current demography and medicine. He illustrates how men have either been completely ignored in fertility analysis or are considered as another, usually problematic, factor in the fertility of women, the main focus of analysis. Men's fertility is seldom considered. The paper builds a framework in which reproduction is considered as a dynamic process between couples and linked to much broader factors such as socio-economic, political, demographic and cultural differentiations, masculinity and male identity, gender organization and gender roles, and sexuality. The author proposes gender-specific conceptual frameworks for considering men's and women's views on reproduction. The paper also proposes new indicators to measure men's fertility and wanted pregnancies—for instance, an individual's reproduction rate, estimating the average number of live born children per male, and the average number of children conceived by common accord.

Foumbi, J. and Lovich, R. ***Role of Men in the Lives of Children.*** New York: UNICEF (1997).
This background paper is part of an ongoing effort to better understand the role that men can play in the lives of children and women. UNICEF's support of activities that focus on men and boys is presented. The paper includes lessons learned and suggestions for the design and evaluation of programs that seek to enhance the positive role of men in the lives of children and to achieve balanced roles and responsibilities within households.

Ndong, I. and Finger, W.R. **Male responsibility for reproductive health.** *Network* 18(3) (1998). Available at: www.fhi.org/en/fp/fppubs/network/v18-3/nt1831.html).
In their introduction to this issue of *Network*, Ndong and Finger provide an overview of key elements in men's involvement in reproductive health. They include program priorities such as encouraging men to support women's contraceptive choices, increasing communication between partners, increasing the use of male methods, involving men in the prevention of STIs, addressing men's reproductive health needs, and encouraging men to become more aware of related family issues and overcoming client and provider biases.

Raju, S. and Leonard, A., eds. ***Men as Supportive Partners in Reproductive Health: Moving from Rhetoric to Reality.*** Population Council (2000). Available at: www.popcouncil.org/pdfs/menaspartners.pdf).
This publication summarizes 20 case studies on male involvement in India. It provides a wealth of information on the practical aspects of involving men in reproductive health programs. The case studies emphasize partnership between men and women with the objective of improving women's reproductive health, decreasing maternal morbidity and mortality, and improving child welfare. The document includes a discussion of common findings and recommendations for future actions.

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Men's influence on women's health

Abdel-Tawab, N. et al. ***Counseling the Husbands of Postabortion Patients in Egypt: Effects on Husband Involvement, Patient Recovery and Contraceptive Use.*** Final report. Population Council, Asia and Near East Operations Research and Technical Assistance Project, Cairo, 1997 December [12], 35 pages. (USAID Contract No. DPE-C-00-90-0002-10).
This study in Egypt evaluated the impact of counseling husbands of abortion clients on their level of support postabortion. The main education and counseling themes for the husbands included (1) the woman's need for rest and nutrition, (2) postabortion warning signs, (3) return to fertility with two weeks, and (4) the need for family planning. The overall impact of the counseling was small, but among subgroups there were some significant effects. For example, among couples with no female members at home to help in the recovery process, the husbands who received counseling were significantly more likely to provide a high level of support to their wives. The counseling was acceptable to both husbands and wives. It was concluded that, as long as the woman's right to privacy is protected, counseling of husbands should be included in postabortion care services.

Berer, M. Men. ***Reproductive Health Matters.*** Number 7: 7-10 (May 1996).
This introduction to a compilation of articles on men and reproductive health summarizes key issues related to the topic. The commentary raises questions about the rationale for involving men, men's power as decision-makers, strategies for involving men, and balancing women's needs versus men's needs. The author also provides insight regarding what women want from men related to sexuality and reproductive health.

Bhalerao, V.R. et al. **Contribution of the education of the prospective fathers to the success of maternal health care programme.** *Journal of Postgraduate Medicine* 30(1):10–12 (January 1984).
This study evaluated the role of involving prospective fathers in the care of pregnant women attending a clinic in Bombay, India. Beginning in October 1982, pregnant women attending the Clinic were requested to ask their husbands to meet with the resident medical officer of the center. The outcome of the maternal health care program for the 270 women

whose husbands were invited and came (Group 1) was compared with the outcome of the same program for 405 women whose husbands could not be invited (Group 2). The husbands who attended the center were educated individually and in groups about their role in nutrition and health of their wives during pregnancy and their responsibility in subsequent child rearing. The physiology of pregnancy, complications of pregnancy, and the possible ways and means of preventing the complications were explained in detail. The husbands also were told to encourage their wives to attend the antenatal clinic of the center as often as possible. The main difference between the two groups was a significantly lower perinatal mortality in Group 1. Furthermore, more women in Group 1 accepted postpartum sterilization than women in Group 2. This effort confirms that the involvement of prospective fathers is possible and pays good dividends even in an uneducated and low socioeconomic community.

de Schutter, M. **"Men and Women's Sexual and Reproductive Health Needs: Competition for Limited Resources or Shared Concerns?"** Pan American Health Organization/World Health Organization. Paper presented at AWID Conference Panel on "Male Involvement in Sexual and Reproductive Health: Hindrance or Help to Gender Equity?" (November 12, 1999).
This presentation examined the question of how to balance men's and women's health needs and interests, given that resources are limited and needs are abundant, including whether the criteria currently exist to set priorities in this area. The author examined current gender inequities and women's disproportionate burden in sexual and reproductive health, particularly in the LAC region. For instance, the current contraceptive use ratios clearly show gender inequities. Given that women bear most of the burden of sexual and reproductive ill health, the author called for special, separate health services for men. The author also questioned the ability of health sector reforms to provide opportunities for including men's needs and men's role as partners without taking away much-needed resources from women's health, given the lack of emphasis on health promotion and prevention, both key strategies in the work with men. The author identified gaps in the research regarding the benefits of involving men in reproductive health programs. The author concluded that, given limited financial and human resources and data that document proven successful strategies with men, at present it is difficult to commit fully to men's health.

Fisek, N.H. and Sumbuloglu, K. **The effects of husband and wife education on family planning in rural Turkey.** *Studies in Family Planning* 9(10–11):280–285 (October–November 1978).
The authors studied the effects of a comprehensive program of family planning education on the knowledge, attitudes, and practice of rural married couples of reproductive age in Turkey between June 1974 to May 1976. Data from a baseline survey were used to assign each of 33 villages to a husband-wife education group, a wife-only education group, or a control group. The groups were similar in terms of (1) the use of effective contraceptive methods, (2) the educational level and age distribution of the women, and (3) the number of surviving children. The information presented to the wives was designed to overcome specific factors that hindered contraceptive use. The emphasis for the husbands was on the adverse effect of high fertility for the family and for the nation. Data collected by auxiliary nurse midwives and in beginning, middle, and end-of-study surveys revealed a significant increase in acceptors in both study groups, with a greater increase in the husband-wife group and a corresponding decrease in discontinuation rates. Measurable changes in attitudes occurred, but these were not statistically significant. The educational activities of this program were absorbed into the regular duties of the district family planning staff; the cost otherwise would have been $25.80/husband and wife/year and $16.50/wife/year. The husband-wife group showed a significant increase in contraceptive use in the second year. The results of this study reveal the importance of continuous and routine involvement of men in family planning education.

Greene, M.E. **"The Benefits of Involving Men in Reproductive Health."** Presentation at the meeting of the Association for Women in Development (Draft) (November 1999).
This analysis looks at how men are being involved in reproductive health and the potential benefits to themselves and others of doing so. The benefits of involving men in reproductive health largely are determined by how programs are involving them. This paper provides examples of the types of male involvement efforts with the greatest potential for promoting gender equity. The analysis concludes that policies that promote gender equity serve the interests of men as well as women, as they increase men's choices and their possibilities for learning and development, as well as the survival and happiness of family members, and they combat the negative aspects of socially constructed aspects of masculinity. The equal participation of men in sharing power over reproductive decision-making and in creating healthy and responsible sexual relationships with their partners also is seen as both a means to promoting women's rights and gender

equity, and an end in itself.

Helzner, J.F. **Men's involvement in family planning.** *Reproductive Health Matters* 7:146–154 (May 1996).
This article looks at the issue of men's involvement in family planning from a gender perspective. The author discusses the importance of taking into account the interplay between men's and women's roles, rather than focusing on women's situation (or men's) alone, with the aim of increasing equality between men and women. The author examines the gender dynamics of contraceptive methods and other issues of male control related to women's reproductive health. The article cautions against implementing men's involvement programs that result in worsening existing male dominance.

Hunter, D.J. et al. **Sexual behavior, sexually transmitted diseases, male circumcision and risk of HIV infection among women in Nairobi, Kenya.** *AIDS* 8(1):93–99 (1994).
This cross-sectional case-control study looked at risk factors for HIV infection among 4,404 women in Nairobi, Kenya. Data were gathered using structured questionnaires and clinical testing for various STIs. Two hundred and sixteen women (4.9%) were HIV-1-positive. Although risk of HIV was significantly increased among unmarried women and among women with multiple sex partners, most seropositive women were married and reported only a single sex partner in the last year. Women with a history or current evidence of STI were at significantly increased risk; the prevalence of these exposures was low, however. Women whose husband or usual sex partner was uncircumcised had a threefold increase in risk of HIV. Only 5.2 percent of women reported ever having used a condom. These data suggest that, among women who are not in high- risk groups, risk of HIV infection is largely determined by their male partner's behavior and circumcision status.

Padian, N.S. et al. **Heterosexual transmission of human immunodeficiency virus (HIV) in northern California: results from a ten-year study.** *American Journal of Epidemiology* 146(4):350–357 (August 15, 1997).
To examine rates of and risk factors for heterosexual transmission of human immunodeficiency virus (HIV), the authors conducted a prospective study of infected individuals and their heterosexual partners who have been recruited since 1985. A total of 82 infected women and their male partners and 360 infected men and their female partners were enrolled. Over 90 percent of the couples were monogamous for the year prior to entry into the study; fewer than 3 percent had a current sexually transmitted infection (STI). Overall, 68 (19%) of the 360 female partners of HIV-infected men (95% confidence interval [CI] 15.0–23.3%) and two (2.4%) of the 82 male partners of HIV- infected women (95% CI 0.3–8.5%) were infected. History of STIs was most strongly associated with transmission. Male-to-female transmission was approximately eight-times more efficient than female-to-male transmission and male-to-female per contact infectivity was estimated to be 0.0009 (95% CI = 0.0005–0.001). Infectivity for HIV through heterosexual transmission is low, and STIs may be the most important cofactor for transmission.

Tapsoba, P. et al. **"Involving Husbands to Increase the Acceptability of Norplant in Antananarivo, Madagascar."** Paper presented at the 121st Annual Meeting of the American Public Health Association, San Francisco, California, October 24–28, 1993, 12 pages (1993).
This study conducted at two family planning clinics in Madagascar from December 1989 to December 1991 investigated whether involving husbands in Norplant® counseling and education had an impact on method continuation and acceptability. Clients choosing Norplant® self selected into two groups, those including and those excluding husbands in counseling activities. Clients with no preference were randomly assigned to a group. Some 496 clients were recruited during the study period. Husband involvement led to lower discontinuation rates (2.3 percent among husband counseled couples versus 8.2 percent among others). Husbands who had received counseling were less concerned about the side effects of the method and the majority of counseled husbands and their wives reported being satisfied with the method.

Terefe, A., et al. **Modern contraception use in Ethiopia: does involving husbands make a difference?** *American Journal of Public Health* 83(11):1567–1571 (November 1993).
This study was undertaken to determine the relative efficacy of home visitation with and without husband participation on the use of modern contraception in Ethiopia. A randomized field trial of a family planning education intervention using home visitation with and without husband participation was conducted in Addis Ababa, Ethiopia, from August 1990 to December 1991 and included a 12-month postintervention follow-up. A total of 266 experimental and 261 control subjects were entered, of whom 91.7 percent and 88.9 percent, respectively, were followed through 12 months. A

greater proportion of couples in the experimental group were practicing modern contraception at 2 months (25% versus 15%) and 12 months (33% versus 17%) following home visits intervention. By 12 months, experimental subjects were less likely to have defaulted and more likely to have started using modern contraception following an initial delay. The inclusion of husbands in family planning programs will result in relevant increases in the use of modern contraception. Researchers noted that there was a post-education delay of greater than 2 months in the initiation of modern contraception for most couples.

Wang, C.C. et al. **Reducing pregnancy and induced abortion rates in China: family planning with husband participation.** *American Journal of Public Health* 88(4) (1998).
This study examined the impact of educating both the wife and the husband about family planning on reducing pregnancy and induced abortion rates in China. Data were obtained from a systematic random sample of women of reproductive age working in 21 factories in Shanghai. 1,800 nonsterilized married women were selected from 27 work units. The intervention differed from the usual family planning programs in that it provided education to women on-site and included education for husbands. Education stressed communication between spouses, sharing responsibility for contraception, and appropriate timing of abortions. The intervention was conducted from January 1991 to September 1992. The odds of pregnancy and abortion were lowest, but not significantly, among women who participated in the education with their spouses. Women using IUDs and receiving the educational intervention with their spouses were significantly less likely to experience a pregnancy and abortion than other subgroups (the educational intervention alone or usual family planning care).

World Health Organization (WHO). **Men's role in improving reproductive health.** *Progress in Human Reproduction Research* 47 (1998). Available at: www.who.int/reproductive-health/hrp/progress/47/news47_1.en.html#3.
This brief article highlights the importance of male involvement for the improvement and protection of sexual and reproductive well-being of both men and women. It explores the challenges that face researchers, including the determination of appropriate services for men, the need for contraceptive methods for men, and the importance of gender-sensitive agendas. The authors conclude that research into these issues is necessary if gender inequity is to be overcome.

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Impact of couple counseling

Becker, S. **Couples and reproductive health: a review of couple studies.** *Studies In Family Planning* 27(6):291–306 (November-December 1996).
This article reviews studies that collected and matched data from both sexual partners on objective reproductive events, attitudes, and intentions, as well as studies that assessed the effectiveness of interventions that targeted couples. For actual reproductive events (e.g., number of live births, ever-use of contraception, years married, abortions), identical responses to the same question occurred less than 90 percent of the time. With respect to fertility and family planning attitudes and intentions, partner concordance was in the range of 60–70 percent. Reproductive health interventions targeted at both partners have resulted, in most cases, in higher rates of contraceptive use and are especially important to reducing transmission of sexually transmitted diseases, including AIDS. The author concludes that couples are the most appropriate focus for reproductive health programs, but acknowledges that costs of program expansion and other issues must be addressed.

Becker, S. and Robinson, J.C. **Reproductive health care: services oriented to couples.** *International Journal of Gynecology and Obstetrics* 61(3):275–281 (June 1998).
This paper outlines possible approaches to integrating couples into the following clinical services: sexual health, sexually transmitted diseases, contraceptive sterilization, contraception, infertility, obstetric care and breast feeding, infant health, and abortion. Implementation of a couple approach to reproductive health services requires that family planning clinics become more "couple-friendly" and health care professionals are trained to examine and care for both men and women. Culturally sensitive operations research on interventions that promote couple participation in contraception is needed. In traditional patriarchal cultures, such an approach has the potential to increase men's involvement as a cooperating

participant rather than a domineering patriarch.

Karra, M.V. et al. **Male involvement in family planning: a case study spanning five generations of a South Indian family.** *Studies in Family Planning* 28(1):24–34 (1997).
This study examines male involvement in family planning practice and decision making in one Indian family over five generations. Data were collected from 152 living family members: information about an additional 26 members who were deceased or unavailable for interview were gathered using interviews with their children and siblings. The majority of the contraception used in this family consisted of male methods (condoms, vasectomy, natural family planning), particularly among older generations who had limited access to methods for women. The participation of men in this family was not necessarily dependent upon changes in gender relations, such as increased spousal communication. Many men in the family reported being motivated to use male methods by external factors, such as desire for the improved economic status of a smaller family.

Renne, E.P. **Gender ideology and fertility strategies in an Ekiti Yoruba village.** *Studies in Family Planning* 24(6):343–353 (November–December 1993).
This case study from Nigeria examines the effects of gender ideology—beliefs about the nature of women and men and their appropriate behavior in society—on reproductive decision making. Despite the persistence of a strong gender ideology emphasizing men's authority over women and traditional beliefs discouraging couple communication about reproductive matters, the research found that many couples discuss family size preferences and contraceptive use. The increased reporting of couple communication about these issues compared with previous research was attributed to higher educational attainment of women and increased availability of contraceptives.

Salway, S. **How attitudes toward family planning and discussion between wives and husbands affect contraceptive use in Ghana.** *International Family Planning Perspectives* 20(2):44–47 (June 1994).
Data on 661 married couples obtained from the 1988 Ghana Demographic and Health Survey were analyzed to examine the attitudes and preferences of couples toward family size, family limitation, and contraceptive use as well as the degree of communication and discussion between husbands and wives. Both the husband and wife in 77 percent of couples shared like attitudes toward family planning: 73 percent approved of family planning. Yet 39 percent of the wives either did not know or misreported their husband's attitude. Even though 76 percent agreed that they wanted no more children, only 44 percent reported the same responses on ideal family size. Only 35 percent of wives and 39 percent of husbands who knew at least one contraceptive method had talked to their spouse about family planning in the last 12 months. Significant independent variables of current contraceptive use included urban residence (RR = 1.53; $P < 0.01$), wife's attitude toward family planning (RR = 8.85; $P < 0.01$), and discussion of family planning between spouses (RR = 2.15–2.17; $P < 0.01$).

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Impact of gender role expectations on men's health

Barker, G. and Loewenstein, I. **Where the boys are: attitudes related to masculinity, fatherhood, and violence toward women among low-income adolescent and young adult males in Rio de Janeiro, Brazil.** *Youth and Society* 29 (2):166–196 (1997).
Qualitative research with 127 low-income young men and women (ages 14 to 30) in Rio de Janeiro found rigid gender roles with males displaying widespread machista values. Males viewed violence toward women as acceptable in many circumstances, with more widespread violence against women reported among youth who live in low-income, marginal areas of the city. The research also identified a small but important minority of progressive males who questioned traditional machista attitudes. In focus group discussions, more progressive males were frequently criticized by machista males. Individual in-depth interviews found that being able to question predominant machista values was related to having a meaningful relationship with a role model who promoted nontraditional gender roles. The research highlights important ways of working with adolescent males to encourage more flexible gender roles. The paper also includes a literature review of research on the social construction of masculinity in Brazil.

Figa-Talamanca, I. et al. **Effects of prolonged autovehicle driving on male reproductive function: a study among taxi drivers.** *American Journal of Industrial Medicine* 30:750–758 (1996).
This study of taxi drivers in Rome was designed to test the hypothesis that exposure to factors such as prolonged sitting, exhaust, and excessive heat might adversely affect the reproductive health of these workers. Researchers interviewed 201 taxi drivers and took biological samples from 72 subjects. These were compared with samples from 50 control subjects from a variety of occupations. Compared to controls, taxi drivers had a significantly lower prevalence of normal sperm (45.8% versus 64.0%). The association was stronger with increased time on the job.

Foreman, M. (ed.). ***AIDS and Men: Taking Risks or Taking Responsibility.*** London: Panos Institute (1999).
This 250-page book contains contributions from Mexico, Tanzania, Ghana, Uganda, Kenya, Russia, Brazil, Malawi, Thailand, Ivory Coast, and Bangladesh. In every country, the behavior of men drives the HIV/AIDS epidemic. Men tend to have more sexual partners than women—and therefore more opportunity to contract and transmit the virus. Men generally decide the frequency and form of intercourse—and many men refuse to use condoms or to have fewer sexual partners. Men's behavior is frequently determined by cultural norms that identify masculinity with sexual prowess; in many cultures to "be a man" is to have frequent sexual intercourse, often with more than one partner. Men's behavior also is associated with risk, such as using drugs or refusing condoms.

Keleher, K.C. **Occupational health: how work environments can affect reproductive capacity and outcome.** *Nurse Practitioner* 16(1):23–34, 37 (January 1991).
This comprehensive review describes occupational hazards to both male and female reproductive health. Occupations with potential risks to men include autoworkers, ceramic and pottery makers, painters, agricultural workers, and laborers involved in the manufacture of medicines, dyes, and other organic compounds.

Khan, S. **South Asian male sexual behaviours and their impact upon male children and youth.** *Naz KiI Pukaar* 21:14–17 (April 1998).
Male-to-male sex is widespread and routine in South Asia across all socioeconomic categories and areas of residence. To ensure that girls remain virginal until married, young men and boys are routinely segregated from young women and girls. Extremely close, affectionate bonds of friendship and intimacy among males are instead created, sanctioned, and even encouraged by society. Friendship and intimacy between males extends into male-to-male sex play and the release of sexual energy. Considerable male-to-male sexual behavior occurs in family environments between uncles and nephews, cousins, friends, and brothers.

Kootikuppala, S.R. et al. **Sexual lifestyle of long distance lorry drivers in India: questionnaire survey.** *British Medical Journal* 318(7177): 162 (January 16, 1999).
This study investigated the sexual lifestyle of long distance lorry drivers in India, who have much higher rates of HIV infection than the general Indian population. A questionnaire was administered to a total of 5,709 long distance lorry drivers passing through a check post between March 1994 and August 1994. 87 percent of subjects (4,949 men) reported having multiple sexual partners; only 11 percent of these men (563) used condoms during commercial sex. The percentage using condoms decreased with increasing age. In the 21–30 age group (n = 1,766), 78 percent of unmarried sexually men with multiple partners (331/425) reported having 31–60 sexual partners during the past 12 months. Almost half of subjects (2,714; 47%) drank alcohol daily early in the morning. A significantly higher proportion of men over 40, compared with men under 21, had multiple partners and misused alcohol and a lower proportion had AIDS knowledge.

Moynihan, C. **Theories in health care and research: theories of masculinity.** *British Medical Journal* 317:1072–1075 (October 17, 1998) Available at: www.bmj.com/cgi/content/full/317/ 7165/1072).
This article presents a sociological view of masculinity. The author examines various theories of masculinity and gender stereotypes and discusses the ways in which these views of masculinity affect both men's use of health services and treatment by the medical community. Specific examples include men's feelings related to loss of sexual organs after treatment for testicular cancer.

Rani M, Figueroa ME, Ainsle R. **The psychosocial context of young adult sexual behavior in Nicaragua: looking**

through the gender lens. *International Family Planning Perspectives.* 2003;29(4):174–181.
This article reviews gender norms among young adults in Nicaragua and how these norms affect their sexual and health-seeking behaviors. The study surveyed 552 never-married women and 289 never-married men, aged 15 to 24, about their perceptions of social pressure to engage in premarital sex; attitudes toward premarital sex and premarital pregnancy; perceived sexual activity among peers and siblings; communication with parents on sexuality issues; the psychosocial context of sexual debut; and preferred sources of information on sexuality issues. Most young men (83%) reported that they had received direct encouragement from at least one person in the last year to engage in premarital sex, and at least half perceived that their father, siblings, other relatives, and friends approved of premarital intercourse. In contrast, women held more negative attitudes toward premarital sex and were more often discouraged by parents or siblings from engaging in sex. In conclusion, reproductive health programs for young Nicaraguans need to address gender-based double standards, which raise the risk of unplanned, unprotected sex and unintended pregnancy.

Rappaport, B.M. **Family planning: helping men ask for help.** In: *Men's Reproductive Health.* Swanson, J.M. and Forrest, K.A. (editors). New York: Springer, 245–259 (1984) (Springer Series: Focus on Men, Vol. 3).
This chapter examines the experiences of the staff of New Ways in Health Education in conducting men's programs. The key problem in developing health programs for men is with the pervasive, rigid roles in which men are placed almost from birth. The lack of male involvement in family planning is part of an overall failure to involve men in health care programs in general. Strategies for outreach to men generally have fallen within four groups: no strategy (simply opening a clinic and waiting for male clients), female model (using a successful female recruiting method to recruit males), macho modeling (endorsement of male involvement in contraception by highly regarded figures) and the male oppression strategy (focusing on the idea that men are as oppressed as women). These approaches have been ineffective and simply promote the rigid adherence to the male role that undermines the ability to involve men in caring and responsible roles in their sexual relationships. A new strategy involves two key assumptions: that the full involvement of men in family planning would be of enormous value to everyone concerned, and that while women bear the greater burden of the rigid sex-role expectations in this society, men also are hurt by these roles. The chapter provides examples of programs dealing with partners of abortion clients, teenagers, and men concerned about infertility and presents special techniques for counseling men.

Ratcliffe, J. et al. **Semen quality in papaya workers with long term exposure to ethylene dibromide.** *British Journal of Industrial Medicine* 44:317–326 (1987).
This study compared sperm characteristics of 46 men exposed occupationally to ethylene dibromide with 43 non-exposed men. The analysis controlled for potentially confounding factors such as smoking, caffeine and alcohol consumption, age, and history of urogenital disorders. Significant differences in sperm count, viability and motility, and morphology were found. The exposure levels of the men studied were near or well below recommended maximum levels.

Annotated Bibliography

This is **page 2** of the Men and Reproductive Health Annotated Bibliography. This page contains:

- Reaching adolescent males
- Men's reproductive health concerns
- Outcomes of "men and reproductive health" programs
- Men and HIV

To access more bibliographic entries, visit page 1 or page 3, or return to the complete list of topics covered in the Men and Reproductive Health Annotated Bibliography. Be sure to use the Glossary if you are unfamiliar with any of the terms on this page.

Please note that PDF files require Adobe Acrobat Reader software, which can be downloaded for free at www.adobe.com/products/acrobat/readstep.html.

Reaching adolescent males

Also see the Annotated Bibliography for the Adolescent Reproductive Health section.

Ajuwon, A. J. et al. **"Sexual Coercion Among Adolescents in Ibadan, Nigeria: The Perspectives of Males."** Paper presented at WHO Afro Regional meeting in Pretoria, South Africa (27–29 September 2000).
This paper summarizes findings from a study in Nigeria that identifies reproductive health behaviors that adolescents perceive as coercive. The most frequently mentioned were rape, unwanted touch, mockery, forceful exposure to pornographic film, and incest. They concurred that perpetrators of sexual coercion are not strangers to their victims, but tend to be boyfriends, fellow students, neighbors, and parents. Participants in the study (15–19 years old) agreed that typically males are the perpetrators and females the main victims. The study recommends that interventions targeting boys should focus on helping them appreciate the consequences of their actions and provide them with the skills that

enable them to take responsible actions in resolving conflicts in their relationship with girls.

Ampofo, A.A.. **Aben wo ha: Socialisation of Boys and Girls and Behavioral Outcomes: Sexual Identity and Practices** [abstract]. Paper presented at WHO Afro Regional meeting in Pretoria, South Africa, (27–29 September 2000).
The paper reviews existing literature on what is known about boys' knowledge about sexual matters, the source of their knowledge and mode of transmission; attitudes about their own sexuality, and the role of sex in their lives, including their attitudes to females and views on gender roles and relations.

Armstrong, B. et al. **Involving men in reproductive health: The young men's clinic.** *American Journal of Public Health* 89(6):902–905 (1999).
This article describes the population served by and the services offered through the Young Men's Clinic in New York City. The clinic was started in 1986 and serves about 1,200 men aged 14 to 34 each year. Services provided include physical examinations, treatment for acute illness, and the management of chronic illness, as well as dealing with issues related to reproductive health and psychosocial problems. A review of clinic data from 1995 revealed that two-thirds of clients had ever been sexually active, three-quarters had ever used birth control, and 69 percent had used birth control at their last sexual encounter. Although most Young Men's Clinic patients had been sexually active for several years prior to their first clinic visit, the predominant reason given for first visits was routine health care needs such as physical examinations. Over one quarter (26%) of the young men who presented for a routine physical examination were also treated for an STI. The findings of this study suggest that young men have a need for and are eager to access reproductive health clinics, especially when the needs they consider important (for example, for sports and school physicals) are addressed as well.

Barker, G. **Boys, Men and HIV/AIDS**. UNAIDS Briefing Paper (second draft). Instituto Promundo, Rio de Janeiro, Brazil, 18 January 2000.
The author provides a broad but comprehensive overview of missed opportunities to engage boys and men in sexual and reproductive health, and makes several recommendations for working with men. His thesis is that engaging men as partners in health and gender equity will lead to slowing the spread of HIV while improving the lives of the men, their families, and their partners. Acknowledging that men, like women, are a diverse group, and addressing the fact that some men engage in multiple sexual relations, including sex with other men, are key elements of Barker's recommendations for slowing the spread of HIV/AIDS and addressing men's health needs. The paper analyses how the socialization of boys contributes to men's risky behaviors. Recommendations for working with adolescent boys wherever boys hang out (such as at schools, workplaces, and military facilities) and lessons learned in working with men, such as providing men with STI treatment and general health care, and engaging satisfied clients to reach other men contribute to the wealth of information found in this paper. The report also describes some of the projects that work with men.

Barker, G. **"Listening to Boys: Some Reflections on Adolescent Boys and Gender Equity."** Paper presented at the AWID Conference Panel "Male Involvement in Sexual and Reproductive Health: Hindrance or Help to Gender Equity?" (November 12, 1999).
This presentation offers insights on adolescent boys and their socialization from the voices of boys themselves and considers the implications of what we know about adolescent boys for working with them to promote gender equity, including greater involvement in reproductive health. The author concludes that promoting gender equity during adolescence may be more effective than later on; evidence suggests that young men frequently are more willing than adult men to consider alternative views about their roles in reproductive health and are in the process of forming their values—values that often shape lifelong patterns. The paper describes the gender-specific health needs and concerns of boys. The author concludes that male socialization has direct consequences for young men's health, including their risk-taking behaviors such as substance use, violence, and unsafe sexual practices. Insights from boys who are identified as having a "gender equity" perspective found that their perspective was shaped by interactions with a relative or family friend or someone in their social circle who either modeled or supported nontraditional gender stereotypes.

Centerwall, E. ***Sexuality Education for Adolescent Boys.*** Swedish Association for Sex Education. Sweden (1995).
The Swedish Association Sex Education (RFSU) published this booklet, which advocates for sexuality education for adolescent boys. An underlining theme is the fact that men's sexual patterns have to change given current trends to

provide women equal opportunity in all aspects of life. Furthermore, men must take on the responsibility of providing information to boys. The text addresses the socialization of young boys by suggesting that parents may hinder adolescent boys' formation of self-identity, and friends give inaccurate information about sexual matters. It underlines the role adult men play in generating self-esteem in young men when they provide guidance and closeness. Nordic sexuality educators are taught to address all matters related to sexuality with a gender and rights perspective. For instance, masturbation is acknowledged and accepted; pornography is discussed in terms of its exploitation of women and the fact that the pictures do not represent real life; and homosexuality is presented in the context of the right to affirm one's sexual identity. .

Erulkar, A.S., and Mensch, B.S. "**Gender Differences in Dating Experiences and Sexual Behaviour Among Adolescents in Kenya**." Paper presented at the 23rd Population Conference of the International Union for the Scientific Study of Population, Beijing (11–17 October 1997).
This study addresses the sexual initiation of adolescents in Kenya. The authors present information about adolescents' attitudes about gender roles (boys have more traditional attitudes than girls); their sexual activity (most young people who engaged in any kind of sexual act also reported engaging in penetrative sex); the role that peer pressure and attitudes about gender play in adolescent sexuality as well as coercion and forced sex. The study finds that peer pressure is an important factor encouraging premarital activity among boys. It also reports that boys who coerce girls into sexual relations scored significantly lower on the gender-role scale than boys who did not exhibit such behavior. Although the study failed to find more conclusive correlations between gender attitudes and sexual behavior, it is progressive in its multi-faceted approach to adolescent sexual activity and its conviction that adolescent sexuality should be studied within the context of adolescents' lives.

Irvin, A. ***Taking Steps of Courage: Teaching Adolescents about Sexuality and Gender in Nigeria and Cameroun.*** New York: International Women's Health Coalition (2000). Available in English, French, and Portuguese at: www.iwhc.org/index.cfm?fuseaction=page&pageID=71.
This report discusses sexuality education approaches for adolescents, particularly the application of gender-sensitive approaches. It includes program examples as well as a list of related resources.

Lundgren, R. ***Research Protocols to Study Sexual and Reproductive Health of Male Adolescents and Young Adults in Latin America.*** PAHO, Division of Health Promotion and Protection/family Health and Population Program, January 2000. Available at: www.paho.org/English/HPP/HPF/ADOL/protocol.htm).
The author proposes an ambitious study on various aspects of male adolescents along with the tools required to undertake it. She discusses the gaps in knowledge about this population, and lists the objectives of her study, which include understanding the significance masculinity holds for youth, identifying socialization patterns that lead to the construction of distinct forms of masculinity, understanding how the meanings of masculinity are manifested in sexual and reproductive heath attitudes and behaviors, and determining where boys and young men obtain information on reproductive and sexual health. The author identifies aspects about male adolescents that need further research. The tools she plans to use, focus group guides, individual interview guides, a survey, and the Informed Consent form she developed are annexed to the paper.

Nnko, S.E.A. "**Risk Behaviours of Male Adolescents in Tanzania: Motives and Patterns of Their Sexual Relationship** ." Paper presented at the WHO/UNAIDS Afro Regional Meeting in Pretoria, South Africa (27–29 September 2000).
The paper presents a review of various research experiences on male adolescents in Sub-Saharan Africa, with a focus on Tanzania. The overview provides extensive data on the prevalence of HIV/AIDS: 1.6 percent among males aged between 15 to 19, and 8.1 percent among males between the ages of 20 and 24. Furthermore, it finds that only 5 percent of male pupils who are sexually active ever used a condom. In Tanzania, researchers question the sugar daddy theory, in which young girls are believed to be likely to have sex with middle aged men; instead, they found that 18- to 25-year-old out-of-school males are the older men that are more likely to seduce young girls. Sexual coercion, the threat or use of force by young men, plays a significant role in sexual encounters among adolescents in Tanzania. The study makes the following recommendations for programs that work with male adolescents: work with young men in school and out of school; design interventions that "fit into existing adolescents' (sub)culture as much as possible," rather than appealing to monogamy or abstinence; promote condom use among adolescents; and work through peer educators.

Pathfinder. **Promoting reproductive health for young adults through social marketing and mass media: a review of trends and practices.** *Focus on Young Adults, Research Series* (16 July 1997).
This paper provides guidance for working with young men in all aspects of sexual and reproductive health while providing detailed information on key elements of social marketing programs. It analyzes strategies used by successful programs and reports on aspects that contributed to their success. The paper summarizes the analytical literature; describes key elements of project design, implementation, and evaluation; and defines critical research questions that enhance the effectiveness of interventions. It defines social marketing as a process that combines techniques used in commercial advertising, market research, and the social sciences to achieve such objectives as increased use of health-related products (condoms), increased access to health services, and changes in health behavior and practices (abstinence or reducing the number of sexual partners). Other topics addressed are audience segmentation, behavioral change, mass media, peer and other forms of interpersonal education, involvement of youth and gatekeepers, training, advocacy, monitoring and management and evaluation tools. A table that summarizes ongoing social marketing young adult reproductive health lists these projects by region and illustrates they key activities.

Senderowitz, J. ***A Review of Program Approaches to Adolescent Reproductive Health.*** USAID: Poptech assignment number 2000.176. (June 2000). Available at: www.poptechproject.com/library/review06_00.htm).
This publication provides in-depth information on program issues related to adolescent reproductive health in developed and developing countries. The paper classifies approaches to adolescent reproductive health under three objectives and describes the strategies used to achieve them: (1) fostering an enabling environment; (2) improving knowledge skills, attitudes, and self-efficacy; and (3) improving health-seeking and safer sex practices. The review includes information about the benefits young men derive from a specific program, and approaches used to attract male adolescents. The bulk of the review provides information on successful strategies such as working in partnership with youth organizations, including schools, community-based organizations, and NGOs that work with young people; youth development projects; peer programs; using mass media; building linkages with employers; and using new technologies, a strategy found to be particularly successful in reaching young men.

Social Marketing for Adolescent Sexual Health (SMASH). **"Results of Operation Research in Botswana, Cameroon, Guinea, South Africa."** Measure Communication Reports (June 2000). Available online at www.prb.org.
This document evaluates social marketing campaigns undertaken in Botswana, Cameroon, Guinea, and South Africa under the guidance of PSI and with funding from USAID. It describes the projects, summarizes the lessons learned, and considers their implication on future programs. The evaluation found that the programs tended to have a greater effect on young women than on young men, suggesting that social marketing program should take into account differences in male and female concerns. Other lessons learned include (1) Changing behavior may require intensive program efforts of at least two to three years; (2) Social marketing programs targeting youth are most effective if they include a carefully designed mix of mass media promotion and interpersonal communication; (3) The promotion of condoms for STI or HIV/AIDS prevention requires careful communication strategies to reduce the stigmas associated with condom use; (4) Youth involvement in program design is beneficial, but guidance and facilitation may be necessary to keep adolescents focused on critical issues; (5) Social marketing programs targeting youth should have measurable objectives and clearly identified assumptions about behavior change; (6) Evaluation is needed to measure the impact of program activities; (7) Greater collaboration among NGOs is needed to advocate successful policy change.

Varga, C. A. "**The Forgotten Fifty Percent: A Review of Sexual and Reproductive Health Literature on Boys and Young Men in Sub-Saharan Africa."** Paper presented at the WHO Afro Regional Meeting in Pretoria, South Africa, (27–29 September 2000).
This literature review begins by making the case for male involvement given boys' early initiation in sexual relations, the need to treat both men and women to curtail STIs and prevent HIV/AIDS, and the fact that the condom, a method for men, is the only one that protects against HIV infection. The author takes a thematic approach in reviewing studies on African men in sexual and reproductive health, and uses his findings to advocate for further research on boys and young men in sub-Saharan Africa. African men's knowledge, attitudes, and practices (KAP) in sexual and reproductive health are beginning to be collected in surveys, such as DHS, but the author points out that these tend to focus on adult and married men and thus little is known about the KAP of young unmarried men. Similarly, studies on youth that examine

their sexual and reproductive KAP, condom use, and knowledge about HIV/AIDS do not focus specifically on males. Furthermore, studies reveal that youth understand the general mechanics of HIV infection but do not clearly understand the mechanics surrounding HIV such as the difference between HIV and AIDS, the concept of a "window period" in HIV testing, the connection between STI and HIV infection, the relationship between blood contact and infection, and assessing the risk posed by a potential partner. The author concludes that masculinity and the issues associated with it are not clearly understood in sub-Saharan Africa and thus requires further research.

World Health Organization (WHO). ***Boys in the Picture.*** Geneva: WHO (2000). Available at: www.who.int/child-adolescent-health/publications/ADH/WHO_FCH_CAH_00.8.htm.
This publication is an advocacy piece for increasing interest in programming for young boys. It makes a case for promoting gender equity to benefit not only boys, but young girls and the whole of society as well.

WHO. ***What About Boys?*** Geneva: WHO (2000). Available at: www.who.int/child-adolescent-health/New_Publications/ADH/WHO_FCH_CAH_00.7.pdf.
This literature on the health and development of adolescent boys highlights program and research implications for program design related to male adolescents in the areas of:

- Adolescent Boys, Socialisation, and Overall Health and Development
- Mental Health, Suicide, and Substance Use
- Sexuality, Reproductive Health, and Fatherhood
- Accidents, Injuries, and Violence

WHO. ***Working with Boys, Program Experiences.*** Geneva: WHO (1999). Available at: www.who.int/child-adolescent-health/New_Publications/ADH/WHO_FCH_CAH_00.10.htm. This is a report of a workshop on adolescent boys that was carried out in May 1999. Among the workshop results was recognizing the need to develop systematic methods that use a gender approach. The workshop also determined that there is a need for a stronger evidence base to address the needs of young boys more adequately.

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Men's reproductive health concerns

Best, K. **Male circumcision and HIV risk.***Network* 18(3) (Spring 1998) Available at: www.reproline.jhu.edu/english/6read/6issues/6network/v18-3/nt1832a.ht ml.
This is a report on male circumcision and HIV risk. Studies in developing countries suggest that men who have been circumcised are at lower risk of HIV infection than men who have not been circumcised. U.S. studies have found no such connection.

Bortolotti, A. et al. **The epidemiology of erectile dysfunction and its risk factors.** *International Journal of Andrology* 20:323–334 (1997).
This review article summarizes the data regarding incidence of erectile dysfunction. Data are extremely limited, especially for populations outside the United States. Proven and potential risk factors—including age, diabetes, smoking, alcohol consumption, various chronic diseases, and use of certain medications—are discussed.

Eschen, A. et al. **"Male Sexuality in Colombia: Implications for New Reproductive Health Services for Men."** Paper presented at the American Public Health Association Annual Meeting (November 1999).
This presentation reports on findings from a qualitative study in Columbia done by the Center for Multidisciplinary Research for Development (CIMDER) in association with AVSC International. Its purpose was to understand men's, women's, and providers' knowledge, attitudes, and needs for sexual and reproductive health services for men. It was

conducted in the five largest cities of Colombia using 60 focus groups, 720 surveys of service users and non-users, 45 interviews with health care staff from 21 service delivery institutions, and 5 life histories of couples. The study groups included male and female adolescents (ages 14–18), young adults (ages 19–35), and adults (over 35). The study found that men surveyed defined their masculinity according to three themes: virility, responsibility, and reciprocity. Forty-six percent of the men and about 36 percent of women surveyed thought that men were sexually responsible. The predominant feeling, however, was that men fit the macho stereotype; they are sexually hyperactive, selfish in terms of their own pleasure rather than the woman's, they lack tenderness, and they are promiscuous. The study also found that men want more than just information about health. Men also wanted to know how to communicate with children and partners as well as foster new ideas about being gender-sensitive in a changing society. Men also showed concern about sexual risks related to their behavior, either through alcohol or going to sex workers.

Hawkes, S. **Why include men? Establishing sexual health clinics for men in rural Bangladesh.** *Health Policy and Planning* 13(2):121–130 (1998).
This article describes the rationale for and experience of establishing STI clinics for men through the Matlab clinic in rural Bangladesh. Recommendations include assessing the acceptability of and need for services in the community, assessing men's health seeking behavior and understanding their concerns, training male health workers to provide services, and using both formal and informal mechanisms to "advertise" services. Though the services were designed to address STIs, the clinic found that a large percentage of men also presented with psychosexual complaints, thereby necessitating additional training for staff in responding to these issues.

Johns Hopkins University Center for Communication Programs. **Helping Involve Men (HIM) CD-ROM** (1999). To request a copy, contact the JHUCCP at popline@jhuccp.org.
This resource provides easy access to important and programmatic literature on men's participation in reproductive health. HIM contains 11,000 pages of journal articles, technical reports, and books. These essential documents will help program officers, NGOs, health workers, and decision makers design programs and services to increase and encourage men's participation in reproductive health activities. The HIM CD-ROM is being distributed at no cost to policy makers and program planners worldwide. It is available free of charge, with preference given to requests from developing countries.

Pinnock, C. et al. **Older men's concerns about their urological health: a qualitative study.** *Australia and New Zealand Journal of Public Health* 22(3):368–373 (1998).
Participants in focus groups identified common urological concerns of older men, including urinary symptoms, prostate cancer, and sexual function. There were many misconceptions about these issues. For some men, urinary concerns were exacerbated by working conditions in which toilets were not readily accessible. Men also identified barriers to taking action on potential health problems, including stoicism and poor relationships with doctors.

Ravi, K., Verma, G., Rangaiyan, S. et al. **Cultural perceptions and categorization of male sexual health problems by practitioners and men in a Mumbai slum population.** Available at: www.hsph.harvard.edu/Organizations/healthnet/SAsia/suchana/0804/rh05 2.html).
This paper presents data comparing practitioners' and community male's cultural perceptions and categorizing of sexual health problems in a Mumbai slum population. An opportunistic sample of 44 practitioners and 56 community men were contacted in the initial qualitative phase of data collection. Each respondent was asked, "what are all sexual health problems faced by men in this community?". The answer to this question generated a large number of sexual health problems identified by both the men and the practitioners. Sexual weakness, itching around genital areas, burning sensation during urination, early ejaculation, wounds on the genitals, and white discharge were among the most frequently mentioned sexual problems. Both practitioners and the men show anxieties related to sexual weaknesses, semen loss, penile size, and impotence. Doctors were more concerned than men about sexually transmitted infections such as syphilis and gonorrhea. Men, on the other hand prioritized anxieties related to semen-loss issues, "heat," and itching problems.

Schwebke, J.R. et al. **Sexually transmitted diseases in Ulaanbaatar, Mongolia.** *International Journal of STD and AIDS* 9(6):354–358 (June 1998).

This study assessed the prevalence of STIs among 137 men and 123 women of mean ages 26 and 28 years, respectively, attending the public health STI clinic in Ulaanbaatar. Overall, study subjects were aged 15 to 62 years and mainly from urban areas. Seven percent of men and 10 percent of women consistently used condoms, and 45 percent of men and 33 percent of women reported ever having had STIs; 31.1 percent, 8.1 percent, and 8.6 percent of men and 10.3 percent, 9.9 percent, and 6.0 percent of women were infected with gonorrhea, chlamydia, and syphilis, respectively; and 19.7 percent of men had nongonococcal urethritis and 67 percent of women had trichomoniasis. Even though no patient was infected with HIV, improved control efforts are urgently needed to prevent the spread of HIV in Mongolia given the existence and communication of STIs in the country.

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Outcomes of "men and reproductive health" programs

Celentano, D.D. et al. **Decreasing incidence of HIV and sexually transmitted diseases in young Thai men: evidence for success of the HIV/AIDS control and prevention program.** *AIDS* 12(5):F29–36 (March 26, 1998).
This study sought to determine whether HIV and sexually transmitted infection (STI) incidence rates among young men in northern Thailand have declined since the establishment of the "100 percent Condom Program." Cohorts of 19–23-year-old men (n = 4,086) inducted into military service between 1991 and 1993 were followed at 6-month intervals (through May 1995) for incident HIV and STI. HIV incidence declined from a rate of 2.48 per 100 person-years during 1991–1993 to 0.55 per 100 person-years during 1993–1995. STI incidence showed an even greater decline, with a 10-fold decrease from 1991–1993 to 1993–1995. Based on these dramatic results, the authors recommend expansion of similar prevention activities to other areas in Thailand and in countries experiencing major epidemics of heterosexually transmitted HIV infections.

Danforth, N. and Green, C. ***Involving Men in Reproductive Health: A Review of USAID-Funded Activities.*** Arlington: Population Technical Assistance Project (1997).
This report catalogues USAID-funded projects that seek to expand the provision of reproductive health services and information to include men of all ages, whether individually or as part of a sexually active couple. Projects include working with local male leaders to support family planning and MCH activities, training providers to serve couples, advocacy, operations and social science research, STI/HIV/AIDS education and services, and community-based distribution. Approximately 12 percent of USAID project funds are spent on men's involvement activities. The document also reports on the results of a survey of USAID and cooperating agency staff regarding their perceptions of constraints and priorities related to men's involvement. Based on the survey results, the report summarizes key obstacles to increasing men's involvement activities (lack of funding and the woman-centered nature of family planning services) and makes recommendations to USAID for improving men's involvement.

Davidson, N. ***Men's Sexual Health Matters.*** London: Healthlink Worldwide (1998).
This easily accessible handbook for health and community workers includes discussions of the rationale for working with men, effective approaches to reach men, men's sexual development and function, common sexual problems men face, and resources for groups working with men. Suggestions for activities are included throughout the text.

Drennan, M. ***Reproductive Health: New Perspectives on Men's Participation*** . *Population Reports* Series J, Number 46, Baltimore, Johns Hopkins University School of Public Health, Population Information Program (October 1998) Available at: www.jhuccp.org/pr/j46edsum.stm).
This issue of Population Reports provides a comprehensive look at men's participation in reproductive health. It includes a discussion of why programs are interested in men as an audience; how men influence the health of women and their families; what survey results show about men's knowledge, attitudes, and behaviors related to reproductive health; the effect of gender issues on couple communication; and lessons learned from program examples. While the primary focus of the issue is on family planning, issues such as men's roles in promoting safe motherhood, reducing STI transmission, and preventing domestic violence also are included.

FOCUS. ***Overview: Key Elements of Youth Friendly Reproductive Health Programs.*** Pathfinder International (1998) Available at: http://pf.convio.com/pf/pubs/focus/RPPS-Papers/OverviewKE.html.
This overview article summarizes the reproductive health concerns of young men and describes various approaches that are being used to meet young men's needs for reproductive health information and services. The article provides examples of programs that reach young men through youth centers, community outreach activities, peer education and counseling, male-friendly clinics, mass media, social marketing, and the workplace.

Green, C. et al. ***Male involvement in reproductive health, including family planning and sexual health.*** Technical Report 28, UNFPA, New York (1995).
This report includes a comprehensive discussion of the rationale for involving men, major program goals, and strategic issues related to planning services. In addition, the report documents key lessons learned from service delivery and information, communication, and education interventions. Throughout the text are case studies of various programs that address men's reproductive health needs.

Gupta, P.K. and Joshi, A. ***Leadership, Responsibility and Men's Partnership With Women to Improve Reproductive Health: A Process Documentation of Designing a 4-Day Training Module for Youth in the Jaunpur Area in Tehri Garhwal District in the Central Himalayas of Uttar Pradesh, India.*** Prepared for The Population Council workshop, *Enhancing the Roles and Responsibilities of Men in Sexual and Reproductive Health* , Kathmandu, Nepal (June 1998).
This detailed report documents the process of developing a four-day training module on gender and reproductive health for youth in rural India. The issue of gender is viewed within the larger context of social injustice, with the training geared toward generating long-term changes in attitudes and behaviors rather than on just imparting knowledge and skills. The report includes findings of qualitative research to determine beliefs and attitudes related to gender, reproductive health, and other related social issues. Also included is an outline of the workshop, including detailed descriptions of some of the exercises and techniques used, and an evaluation of the workshop's impact.

Healthlink Worldwide. ***Men's Sexual Health Matters.*** London: Healthlink Worldwide (1998).
This publication provides practical information for people who are working with men on sexual health or would like to start working with men. It looks at ways of engaging men in discussions about sexual health and sexual responsibility, and men's role in reducing the incidence of unwanted pregnancy, sexually transmitted diseases, and sexual abuse.

IPPF/RHO and AVSC (now EngenderHealth). ***Cinco Casos de Estudio Para el Simposio Sobre Participacion Masculina en la Salud Sexual y Reproductiva: Nuevos Paradigmas.*** Oaxaca, Mexico (October 1998).
This report includes four themes: fatherhood, violence, sexuality, and the social construction of masculinity. Content is focused on examples from Latin America including detailed case studies from MEXFAM (Mexico), ECOS (Brazil), CISTAC (Bolivia), Profamilia (Colombia), and Salud y Género (Mexico). The report includes programmatic recommendations based on discussion at the Oaxaca Symposium. English summaries of the studies are available on EngenderHealth's Men as Partners website (www.engenderhealth.org/ia/wwm/index.html).

IPPF/RHO and AVSC (now EngenderHealth). ***Men as Partners Initiative: Summary Report of Literature Review and Case Studies.*** New York (1998).
Very comprehensive look at men and reproductive health theory, research, and programs in the Americas; emphasis is on Latin America. (Available in Spanish and English.)

Johns Hopkins Center for Communication Programs. ***Reaching Men Worldwide: Lessons Learned From Family Planning and Communication Projects, 1986–1996.*** Working Paper No. 3, Johns Hopkins Center for Communication Programs/Population Communication Services/Population Information Program, Baltimore, Maryland (January 1997).
This publication reviews strategies and lessons learned about communicating with men based on 10 years of program experience. The report includes summaries of 20 projects from around the world. Topics covered include designing and implementing programs, advocating for programs, and evaluating program results.

Liow, M.L. et al. **Innovative approaches to population programme management: Men and reproductive health.**

Innovations 4 (1996).
This volume provides a useful summary of the issues facing programs wishing to reach men with reproductive health services. Also included are descriptions of the approaches and lessons learned from programs serving men in eight countries. Examples include empowering women farmers through men in Indonesia, a men's reproductive health service delivery project in the Philippines, men-only clinics in Colombia, increasing men's involvement in family planning in Ghana, reaching men through the media in Zimbabwe, and social marketing campaigns in Pakistan, Philippines, and Viet Nam. Key to the success of all activities was the involvement of men in the design and implementation of the program activities.

Robey, B. et al. ***Men: Key Partners in Reproductive Health: A Report on the First Conference of French-Speaking African Countries on Men's Participation in Reproductive Health.*** March 30–April 3, 1998, Ouagadougou, Burkina Faso (1998).
This conference focused on identifying strategies to reach men in French-speaking African countries, with emphasis on overcoming barriers to men's participation and building on decision-making traditions in the region. The report includes a summary of research findings related to men's participation in reproductive health, a summary of obstacles to men's participation and strategies for overcoming them, country action plans from 12 countries in the region, and a list of conference resolutions and recommendations.

Rojanapithayakorn, W. et al. **The 100 percent condom program in Thailand** [editorial]. *AIDS* 10(1):1–7 (January 1996).
This nationwide "100 percent Condom Program" aims to ensure that clients of sex workers use condoms during every act of sexual intercourse. It combines a mass media campaign (radio and television) with free condom distribution at sex establishments. In addition, when clients present with STIs at government clinics, clinic workers trace the STI back to the commercial establishment and begin procedures aimed at encouraging the establishment to comply with the 100 percent condom program. At the start of the program, members of Provincial AIDS Commissions met with owners of all commercial sex establishments to discuss the current AIDS situation, how the program worked, how compliance would be monitored, what the penalties were for noncompliance, and the benefits to establishment owners. During 1989–1994, condom use in sex establishments increased from about 14 percent to more than 90 percent, and the STI rate decreased by more than 85 percent. The key factor contributing to the success of the program is that it focuses on a limited goal (i.e., use of condoms in sex establishments).

Wegner, M., et al. **Men as partners in reproductive health: from issues to action.** *International Family Planning Perspectives* 24(1):38–42 (March 1998).
This article describes the outcome of an AVSC sponsored workshop on men and reproductive health held in Mombasa. National level action plans were developed by participants at the meeting. The article details the steps needed to put these plans into action. Available in English, French, and Spanish.

Yinger, N. and Murphy, E. **Illustrative indicators for programming in men and reproductive health.** Washington, DC : PATH. (October 1999).
This document builds on the three "values" developed by the Gender Working Group Men and Reproductive Health Subcommittee. It provides examples of programming and indicators under three core objectives. Detailed tables illustrate the kinds of programs that could be developed to achieve these objectives as well as the kinds of indicators that could be used to measure their success.

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Men and HIV

Aggleton, P. ***Men's Role in HIV Prevention and Care*****.** Thomas Coram Research Unit, Institute of Education, University of London (2000).
The author presents strategies for embracing men as part of the solution to HIV prevention. He proposes the need for new

frameworks that place men alongside women in the global response to HIV and AIDS. Issues addressed in the paper are the socialization of boys, working with younger and older men, breaking the silence about sex, sexuality (including men having sex with men), and stigma. The author also takes a broader view of issues associated with the disease that need to be addressed, such as poverty, alcohol, and drug use. The paper concludes with several policy implications ranging from redefining masculinity to providing job opportunities to young men, to rendering service provision more "men sensitive and men friendly."

Foreman, M., ed. ***AIDS and Men: Taking Risks or Taking Responsibility?*** Panos Institute and Zed Books, London (1999).
This book argues that the AIDS epidemic cannot be contained until men are persuaded to reassess their traditional concepts of masculinity. It examines the relationship between men and HIV/AIDS, and suggests that one in four men world-wide have sexual and drug-taking behavior that places themselves and their partners at risk from infection by HIV. The first section of the book explores the impact of men's actions and attitudes on women, children, and other men, and looks at initiatives designed to help men protect themselves and their partners. The second section contains reports written by journalists from Asia, Africa, the Americas, and Eastern Europe that illustrate the way the epidemic affects all men.

Panos Institute. ***Young Men and HIV - Culture, Poverty and Sexual Risk.*** Briefing No. 41. London: Panos Institute (July 2001). Available at: www.panos.org.uk..
There are one and a half billion young people under the age of 25 in the world today. Their behavior, attitudes, and beliefs will shape tomorrow's world. They are also very vulnerable, especially to sexually transmitted infections, including HIV. Young people experiment with sex, as with other things in their lives. Approximately 60 percent of HIV infections are found in this age group and over half of the world's population has had unprotected sex before the age of 16. This report argues that AIDS-prevention programs must target young men as well as young women. Many young men know very little about the disease or about where to go for information. They are constrained by the desire toimpress their peers, hide their emotions, and show strength rather than weakness. But because they are still young, change is possible. There is enormous potential to slow the epidemic down. Evidence shows that young men can learn responsible sexual behavior. The full report can be downloaded as a PDF or in a text-only version from the PANOS website.

Scalway, T. **"Young Men and HIV in Africa: Challenges and Opportunities."** Paper presented at the UNAIDS African Development Forum (December 2000).
This paper provides a comprehensive analysis of the factors that contribute to young men (aged 15–24) driving the HIV epidemic (e.g., non-use of condoms, sex between men, low perception of HIV/AIDS risk) and the analytical tools used to understand gender and gender relations, which are key factor in understanding the spread of HIV. The author argue that young African men's exposure to global media images that idealize unobtainable lifestyles; the mixed messages they receive in school, in church, and from sexual health providers; and the fact that they are lumped together as one group—and the resulting frustration—works against efforts to stem the epidemic. The author concludes by summarizing "tried and tested methods" that have worked elsewhere: peer education, school and media interventions, sports, youth groups, and adapting indigenous traditional rituals and ceremonies by weaving in messages that promote reproductive and sexual health.

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RHO : Topics : Men and Reproductive Health

Annotated Bibliography

This is **page 3** of the Men and Reproductive Health Annotated Bibliography. This page contains:

- Dual protection
- Gender-based violence
- Men's attitudes toward family planning
- Vasectomy and cancer
- New contraceptives for men

To access more bibliographic entries, visit page 1 or page 2, or return to the complete list of topics covered in the Men and Reproductive Health Annotated Bibliography. Be sure to use the Glossary if you are unfamiliar with any of the terms on this page.

Please note that PDF files require Adobe Acrobat Reader software, which can be downloaded for free at www.adobe.com/products/acrobat/readstep.html.

Dual protection

Bankole, A., and Singh, S. **Couples' fertility and contraceptive decision-making in developing countries: hearing the man's voice.** *International Family Planning Perspectives* 24(1) (1998).
This study examined the reproductive preferences and behavior of married men and their wives in 18 developing countries. Its objectives were to understand the role of husbands in reproductive decision-making. The authors analyzed DHS collected between 1990 and 1998 in eighteen developing countries, thirteen in Sub-Saharan Africa, two in North Africa, two in Asia, and one in Latin America. The study considers childbearing goals, whether reproductive goals differ in polygamous versus monogamous marriages, how contraceptive knowledge translates into reproductive behavior, fertility intentions, and contraceptive use. The study's findings are informative and in some cases raise further questions or suggest that more work is needed to understand gender differences in reproductive preferences and behavior. For instance, findings indicate that husbands and wives differ in their fertility goals, and that these differences and their

importance regarding reproductive behavior vary across countries and regions. Results show a difference between Sub-Saharan Africa, where couples are more likely to agree on having another child than to stop childbearing, while the opposite is true in Asia, Latin America, and Africa. The study also found that the preference for smaller families tends to occur first among wives and determines husbands' roles in achieving smaller families. Inconsistency in spousal reporting of contraceptive use was found to be evident in all 18 countries included in the study.

Cates, W., et al. ***Dual vs. Duel(ing) Protection against Unintended Pregnancy and Sexually Transmitted Infections: What Is the Best Contraceptive Approach?*** Family Health International. (Submitted for publication).
This paper advocates for the use of dual protection – that is, use of family planning methods that protect against STIs and unintended pregnancies. It recognizes, however, the dilemma providers face in choosing a single or two-method dual-protection approach. The authors review the advantages and disadvantages of each approach. The two-method dual-protection approach promotes the use of contraceptive methods that are highly effective in pregnancy prevention (sterilization, implants, injectables, IUDs) in conjunction with the condom, which is highly effective at preventing STIs. Arguments against this approach include the difficulty of motivating people to use two approaches, the fear that adding a second method will impair consistent use of the first, concern about stigmatizing the condom by promoting it as a method that prevents disease, and the costs of promoting two methods. The single-method approach relies on the condom to protect against pregnancy and disease. The authors grapple with the consequences of contraceptive failure, the primary drawback of this approach, and suggest that clinicians tailor their counseling messages to individual client's need and motivations.

John Hopkins University School of Public Health. **Closing the condom gap.** *Population Reports,* Series H, No. 9 (April 1999).
This issue of *Population Reports* provides extensive data on current condom use, the effectiveness of condoms as a contraceptive and in preventing STIs, why more people don't use them, and what programs can do to promote condom use (i.e. create a positive image of condoms, change attitudes, improve access, and provide counseling). An extensive part of the report is devoted to AIDS and STI prevention. It includes data on knowledge about AIDS and about the condom's role in preventing AIDS. Two pages are devoted to protecting young people and the lessons learned from sex education and condom distribution programs. Information about female condoms, recent improvements in condom design, and new barrier methods under development also is provided.

Marcham, C. et al. ***Dual Protection: Reappraising the Condom as Contraception.*** WHO, Department of Reproductive Health and Research (background document for a meeting held in October 1999).
This discussion paper was prepared for a WHO consultation intended to build a better understanding and a closer alliance between family planning and STI/HIV prevention activities. It begins by providing a historical background of the shift reproductive health programs have been forced to make as a result of the AIDS epidemic in terms of including STI/HIV prevention in the scope of services they provide. The paper addresses the confusion surrounding dual protection and clarifies some of the perplexities by defining the "dual method-dual purpose" and "single method-dual purpose" approaches. The paper advocates for the integration of pregnancy prevention and STI services and supports the condom, when used consistently and correctly, as the only method that protects against STIs and as an effective method of contraception.

Nzioka, C. "**Obstacles in Managing the Dual Risks of Unwanted Pregnancy and Sexually Transmitted Infections Among Young Men in Kenya**." Paper presented at the WHO/UNAIDS Afro Regional Meeting in Pretoria, South Africa (27–29 September 2000).
This paper defines the barriers that face programs seeking to promote dual protection among young men in Kenya. The author provides statistical data on young men's risky behaviors—including early sexual experimentation, multiple partners, paid sex, and irregular and rare condom use—that contribute to high rates of HIV and unwanted pregnancy. He proposes various reasons why young men's awareness of the dual protective role of condoms has not produced behavioral changes, including ineffective AIDS awareness messages, programs failure to address gender power relations and cultural norms, young men's reluctance to seek treatment, misconceptions about condom use, and young men's belief they are invulnerable. The paper also suggests that young men are concerned about cost (of condoms), embarrassed, and lack awareness of sources of condom supplies. The second part of the paper includes information about boys' attitudes

regarding sex and reproductive health, and how they view their roles and responsibilities in this area. In the conclusion, the author provides recommendations for how programs can respond more directly to the concerns expressed by young men.

Pranitha, M**. "Prevention of Unwanted Pregnancy and HIV Infections: Perspectives of Young Men and Women**." Paper presented at the WHO/UNAIDS Afro Regional Meeting in Pretoria, South Africa (27–29 September 2000).
This report summarizes findings from focus group discussions on pregnancy prevention and HIV with young men and women in South Africa. Themes addressed include unwanted pregnancy, knowledge of STI/HIV prevention and condom use, protection against unwanted pregnancy and HIV infection, communication among partners, and use of dual methods of protection. Gender inequality and power issues in sexual relations are pervasive themes throughout the paper, and lead the author to recommend that programs find new and innovative strategies of involving men, challenge traditional gender stereotypes, promote new ways of looking at gender roles, and address gender-based violence. The author advocates the use of peer groups to disseminate health information and redefine sexual norms.

Spieler, J. "**Setting the Stage."** Paper presented at USAID Open Forum on Dual Protection (October 2000).
This paper, an introduction to a series of papers on *Dual Protection* presented at a USAID Open Forum on Dual Protection (October 2000), defines dual protection and proposes strategies and actions for integrating dual protection into family planning programs. Dual protection is defined as protection from pregnancy and STIs/HIV either through the use of a condom alone or the use of a condom plus another contraceptive method. Abstinence, or avoidance of penetrative sex, is other means of achieving dual protection. The author highlights implications for service delivery of a dual protection strategy and proposes that effective dual-protection programs require providers and policy makers to change their attitudes and reach out to men. Other proposed actions to achieve results include expanding behavior change communication, promoting condoms, and improving existing condoms.

Stanback, J. "**FP/RH Clinic-Based Programs: Dual Protection in FP Clinics."** Paper presented at USAID Open Forum on Dual Protection (October 2000).
The paper summarizes the strategy used in Kenya to integrate dual protection in family planning programs and illustrates the difficulty of assessing the outcomes of such programs. With technical assistance from JHPIEGO, the Ministry of Health revised service delivery guidelines to emphasize dual protection. Health care providers nationwide were trained to advise on condom use in addition to contraceptive methods regularly used by clients. Post-training evaluation show a significant increase in the proportion of clients receiving information about dual protection. However, it is unclear what proportion of clients accepted and used condoms. The author concludes that achieving dual protection is difficult because it involves many complex issues. The author proposes (1) using a "threshold matrix" to group people by their reproductive intentions and STI risk, and (2) acknowledging and addressing the barriers to condom use—such as women encountering violent opposition from their husbands—as strategies to increase the success of dual protection programs.

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Gender-based violence

Also see the Annotated Bibliography of RHO's Gender and Sexual Health section.

Barker, G. and Acosta, F. ***Preventing Violence Against Women in Partnership with Men: Instituto Promundo and Instituto Noos.*** Rio de Janeiro, Brazil (October 2000).
The paper provides an overview of domestic violence in Brazil and summarizes initial findings on the contributing factors. The paper also includes information about activities Instituto Promundo and Instituto Noos are undertaking. Factors that contribute to male violence mentioned in this paper include (1) sexual or "gender scripts," which justify violence by men; (2) violence against women, which is deeply rooted in the socialization of men and boys; (3) domestic violence, which is associated to economic stress; (4) the cyclical nature of domestic violence; men who witnessed or experienced physical abuse are more likely to use violence against their own partners and children; (5) violence in intimate relationships, which often starts during adolescence; and (6) men's silence about other men's violence. One of

several initiatives described in the paper is a program initiated by Promundo, with funding from PATH. The program trains young men in two low-income communities as peer promoters on prevention of domestic, dating violence, and HIV/AIDS.

Gerstein, L. **In India, poverty and lack of education are associated with men's physical and sexual abuse of their wives.** *International Family Planning Perspectives Digest* 26(1) (March 2000). Available at: www.agi-usa.org/pubs/journals/2604400.html.
This article summarizes the profiles of men who participated in a study on gender violence in Uttar Pradesh. Between 18 and 45 percent of husbands in the study reported physically abusing their wives. Data on the profiles of these men is extensive, and includes demographic factors (age, caste, educational level men who physically and sexually abuse their wives), number of violent incidents, sexual and reproductive behaviors including premarital sex and extramarital relationships, and poverty. The study concludes that men with little education and in extreme poverty are more likely to abuse their wives.

Hayward, R.F. "**Needed: A New Model of Masculinity to Stop Violence Against Girls and Women."** UNICEF Regional Office for South Asia. Paper presented to the WHO Global Symposium on Violence and Health, Kobe, Japan (12–15 October 1999).
This paper summarizes findings and excerpts interviews with men and women activists working to stop the violence against girls and women in South Asia. The author reports on the activities men from Afghanistan, Bangladesh, India, Nepal, Pakistan, and Sri Lanka from various economic strata are undertaking, what motivates them to do this type of work, the role fathers play in inspiring daughters to become activists, and the commonalties between men and women activists. The Katmandu Commitment on Ending Violence Against Women and Girls in South Asia is annexed to the paper.

Heise, L., Ellsberg, M. and Gottemoeller, M. **Ending violence against women.** *Population Reports* Series L, No. 11. Baltimore, Johns Hopkins University School of Public Health, Population Information Program (1999). Available at: www.jhuccp.org/pr/l11edsum.stm.
This issue of *Population Reports* is dedicated to gender-based violence. It explores the cause of violence against women; the role culture plays in condoning such violence, its impact on reproductive health; sexual abuse and coercion; and more. "An Agenda for Change" and an extensive bibliography round out the extensive information provided in this report.

Kaufman, M. **"Involving Men and Boys: A Necessary Step in Ending Violence Against Women and Children**." Paper presented at UNICEF's Partnership and Participation Section Workshop (March 2000).
The paper provides data about the prevalence of men's violence as well as its origins, which the author categorizes into "The Seven P's of Men's Violence". These are men's power and the submission of women; men's sense of entitlement to privilege; and the social permission we have given to the violence; the impossibility of meeting the psychic demands of manhood and the use of violence as a compensatory mechanism; the psychic armoring which keeps men out of touch with pain and feelings, theirs as well as those around them; the crippling prohibition of expressing emotions; and past experiences as witnesses to violence. The paper then proposes actions to address the problem, such as the use of media campaigns, programs in schools with perpetrators and/or parents, and rallies and marches. Involving men in finding solutions as well as basing these within a gender approach are critical elements of the strategies proposed by the author.

Kaufman, M. **"Conflict Resolution: Finding Better Ways to Help Boys and Girls Solve Problems**" Paper presented at UNICEF's Partnership and Participation Section Workshop (March 2000).
This paper addresses conflict-resolution approaches introduced in schools as a means to teach boys and girls life skills and techniques for resolving conflicts through constructive, peaceful strategies. It defines conflict resolution as an "umbrella term for different approaches that recognize that conflict is normal and need not be destructive." The author lists key elements of this approach, which are based on the premise that the problem is not conflict but what people do under these circumstances. Turning conflict into opportunity, being non-adversarial, problem-solving, focusing on the problem itself rather than on who is right or wrong, talking it through, are among some of the key elements mentioned. The author ends by suggesting that conflict resolution is a valuable tool for resolving problems between adults and children, serving the dual purpose of adults using and thus promoting a value system that believes in a nonviolent

resolution to conflicts.

Kaufman, M. **"Positive Strategies with Boys to End Violence"** Paper presented at UNICEF's Partnership and Participation Section Workshop (March 2000).
The author begins this paper by explaining how violence is internalized in boys through their socialization. The belief that men should always be in control and are entitled to power contributes to violence in men; as does homophobia, because boys and men use violence as a means of showing they can measure up to the expectations of manhood. The author proposes teaching boys a "language of emotions" to help them understand their own and others' feelings as a strategy to reduce violence. He also suggests that sports should change their emphasis from conquest and competition to fitness and cooperation. The paper ends with brief descriptions of two programs: The White Ribbon Campaign (www. whiteribbon.ca) and Boys for Babies, aimed at ending men's violence toward women and children.

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Men's attitudes toward family planning

Dodoo, F.N. **Men matter: additive and interactive gendered preferences and reproductive behavior in Kenya.** *Demography* 35(2):229–242 (1998).
This study explores the relative strengths of men's and women's preferences in the determination of reproductive behavior using data from the 1989 and 1993 Kenya Demographic and Health Surveys. The findings indicate that contraceptive use increases when both spouses want no more children. In addition, contraception is two to three times more likely to be used when husbands rather than wives want to cease childbearing. The analysis finds that a wife's preference for stopping childbearing does not translate into increased contraceptive use when her husband wants more children, emphasizing the influence of men on this decision. The author concludes that efforts to improve the status of women or women's negotiation skills with men may be ineffective if the bases of men's reproductive decision making power and men's preferences are not well understood and also addressed through services or interventions. The author further concludes that more must be done to understand the inclinations, preferences, and behavior of men as programs work to implement successful fertility policies in sub-Saharan Africa.

Ezeh, A.C. et al. ***Men's fertility, contraceptive use, and reproductive preferences.*** Demographic and Health Surveys Comparative Studies No. 18, Calverton, MD: Macro International, Inc. (1996).
This report analyzes data from DHS surveys of men in 17 countries. The report summarizes regional and gender differentials in fertility levels, reproductive preferences, knowledge of methods, approval of family planning and current use, and intentions for future use. Ample tables and graphs allow for easy access to data and comparison between countries.

Karra, M.V. et al. **Male involvement in family planning: a case study spanning five generations of a South Indian family.** *Studies in Family Planning* 28(1):24–34 (1997).
This study examines male involvement in family planning practice and decision making in one Indian family over five generations. Data were collected from 152 living family members: information about an additional 26 members who were deceased or unavailable for interview were gathered using interviews with their children and siblings. The majority of the contraception used in this family consisted of male methods (condoms, vasectomy, natural family planning), particularly among older generations who had limited access to methods for women. The participation of men in this family was not necessarily dependent upon changes in gender relations, such as increased spousal communication. Many men in the family reported being motivated to use male methods by external factors, such as desire for the improved economic status of a smaller family.

Kulczycki A. **The determinants of withdrawal use in Turkey: a husband's imposition or a woman's choice?** *Social Science and Medicine.* 200;59(5):1019–1033.
This study investigates why Turkish couples have one of the highest rates of withdrawal in the world, with approximately

25 percent of Turkish couples relying on withdrawal, a percentage which has remained constant for the past twenty years. This study analyzes data from the 1998 Demographic and Health Survey from 1,950 married men. Although there were many variables analyzed, use of withdrawal reflects husbands' authority and preference over other contraceptive methods, although male authority may have only partial predictive power. The results of this study can provide insight into how the effectiveness of Turkey's family planning and reproductive health programs might be improved.

Roudi, F. and Ashford, L. ***Men and Family Planning in Africa.*** Population Reference Bureau; Washington, DC (1996).
This chartbook illustrates the findings from Demographic and Health Surveys in 14 African countries. It includes information about demographic trends, ideal and actual family size, decision making about family matters, family planning knowledge, attitudes toward family planning, family planning practice, and demand for children and need for family planning. The chartbook format is especially useful for those seeking succinct information for presentation to policy makers and others.

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Vasectomy and cancer

Bernal-Delgado, E. et al. **The association between vasectomy and prostate cancer: a systematic review of the literature.** *Fertility and Sterility* 70(2):191–200 (August 1998).
The authors conducted a systematic review of the literature and meta-analysis to evaluate the possible association between vasectomy and prostate cancer. Fourteen original studies published between January 1985 and December 1996 were reviewed (five cohort and nine case-control studies. No causal association was found between vasectomy and prostate cancer. Individuals who have undergone vasectomy are not at high risk for the development of prostate cancer.

Moller, H. et al. **Risk of testicular cancer after vasectomy: cohort study of over 73,000 men.** *British Medical Journal* 309:295–299 (July 1994).
A large Danish study (of over 73,000 men who had vasectomies between 1977 and 1989) found no association between vasectomy and testicular cancer; data were insufficient to evaluate vasectomy and prostate cancer.

Platz, E.A. et al. **Vasectomy and prostate cancer: a case-control study in India.** *International Journal of Epidemiology* 26(5):933–938 (October 1997).
This case control study evaluated the relation between vasectomy and prostate cancer in a population without routine prostate cancer screening in India. 175 prostate cancer cases were compared with 978 controls with cancer diagnoses other than prostate cancer. Standardizing by age, 8.7 percent of cases and 8.3 percent of controls had had a vasectomy. The odds ratio for prostate cancer comparing men who had had a vasectomy to those who did not was 1.48 (95% CI = 0.80–2.72) controlling for age at diagnosis, smoking status, alcohol drinking, and other demographic and lifestyle factors. Risk of prostate cancer associated with vasectomy appeared to be higher among men who underwent vasectomy at least two decades prior to cancer diagnosis or who were at least 40 years old at vasectomy. Although not statistically significant, the results of this hospital-based case-control study are consistent with the hypothesis of a positive association between vasectomy and prostate cancer. Because routine prostate cancer screening is not common in this population, detection bias was unlikely to account for this association.

Rosenberg, L. et al. **The relation of vasectomy to the risk of cancer.** *American Journal of Epidemiology* 140(5):431–438 (September 1994).
A U.S. research team that previously reported an association between vasectomy and prostate cancer found no association between vasectomy and any cancer in a study of 4,126 men with cancer and 7,027 controls.

Zhu, K. et al. **Vasectomy and prostate cancer: a case-control study in a health maintenance organization.** *American Journal of Epidemiology* 15;144(8):717–722 (October 1996).
This case-control study was conducted in Washington State to evaluate the relationship between prior vasectomy and the

risk of prostate cancer. The study compared 175 men newly diagnosed with prostate cancer during 1989–1991 with 258 controls, matched to cases on birth year and membership in a health maintenance organization. Analyses showed that the odds ratio for prostate cancer associated with vasectomy was 0.86 (95 percent confidence interval 0.57–1.32) after adjustment for confounders. The odds ratio estimate did not differ substantially by age at vasectomy or time since vasectomy. However, the odds ratio estimate for prostate cancer associated with vasectomy tended to be increased among men who had a father or brother with prostate cancer; the authors state that the increased risk may be related to detection bias or differential participation rates due to both vasectomy status and a family history of prostate cancer. The results suggest no overall association between vasectomy and prostate cancer.

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New contraceptives for men

AVSC International and Reproductive Health Alliance Europe (RHAE). **Male contraception: Planning for the future.** Report of a symposium held in London (May 12–13, 1999).
This report includes summaries of discussion about developments in male contraception, including the status of research on methods of contraception for men and the time frame for these methods becoming available; service delivery needs regarding working with men, including the importance of gender issues; and development of a draft research agenda to meet the needs of service providers as they prepare for new male contraceptive technologies.

BBC World News. **Male pill breakthrough.** (April 14th, 1999). Available at: http://news.bbc.co.uk/hi/english/health/newsid_315000/315659.stm.
Results from limited clinical trials of a contraceptive pill (containing progesterone) and hormone patch (containing testosterone) for men are encouraging. A three-month course of the pill used in combination with the hormone patch reduced the number of active sperm to zero in most of the 23 men tested. Once men stopped taking the pill patch, their sperm counts gradually returned to normal. Further research is needed to refine the method.

Best, K. **Contraceptive update: experimental male methods inhibit sperm.** *Network* 18(3) (Spring 1998) Available at: http://www.reproline.jhu.edu/english/6read/6issues/6network/v18-3/nt183 5.html.
This article includes a table (www.reproline.jhu.edu/english/6read/6issues/6network/v18-3/nt1835a.html) summarizing research on experimental male methods to inhibit sperm.

Cohen, P. **Sugar pill holds promise for male contraceptive.** *New Scientist* 149(2019) (March 2, 1996).
In the description of this study's results, the addition of a sugar pill to male rat drinking water reduced fertilization rates by 98 percent.

CONRAD. **Mechanical barrier methods for men: Tactylon.** (1999).
This summary of the development of improved male condom materials concludes that new materials resist breakage and deterioration when stored under adverse conditions and increase user comfort.

CONRAD. **Systemic hormonal methods for men.** (1999) Available at: www.reproline.jhu.edu/english/1fp/1advances/1male/1mhorm.htm.
This report includes information on the development of systemic hormonal methods for men, including androgen/progestin combinations, androgens in combination with other suppressive agents, and GnRH analogs.

CONRAD. **Systemic nonhormonal methods for men.** (1998) Available at: http://www.reproline.jhu.edu/english/1fp/1advances/1male/1mmeth.htm.
This article reviews systemic nonhormonal methods for men that are currently under development, including testicular and post-testicular agents and immunocontraceptives.

Lissner, E.A. **Frontiers in nonhormonal male contraception: a call for research** (1994). Available at: www.gumption.org/mcip/paper.html.
This paper describes the current state of research in two areas of nonhormonal male contraception: vas-based methods (no-scalpel vasectomy, chemical injection, injectable plugs, the Shug, and SMA) and heat methods (simple wet heat, artificial cryptorchidism, polyester suspensories, and ultrasound). The paper summarizes issues of safety, effectiveness, convenience, and reversibility for each potential method.

Waites, G. **Male contraception: hormonal aspects.** *International Society of Andrology Newsletter* (1997). Available at: http://andrology.org/clients/~isa/Members/janos/contraception/1997090106.
This site reports on a symposium sponsored by WHO. The three speakers addressed the progress in the development of hormonal means of suppressing sperm production in men of reproductive age and the likely efficacy and safety of such methods. Approaches discussed included a combination of progestin with relatively low dose androgen supplementation; development of long-acting testosterone esters to replace testosterone enanthate (TE) for intramuscular application; GnRH analogues for sperm suppression; and several new male antifertility diterpene epoxide compounds that have been isolated from root extracts of the plant Tripterygium wilfordii.

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Program Examples

The following programs described below illustrate some of the strategies and efforts to involve men in reproductive health in low-resource settings, and outline the lessons learned from program experience.

Submit your own Program Example

- Brazil: Engaging young men in gender-based violence prevention and sexual and reproductive health promotion.
- India: Central Himalayas: Leadership, responsibility, and men's partnership with women to improve reproductive health.
- India: Gujarat State: Enhancing roles and responsibilities of men in women's health.
- India: Nandesari: Involving men in antenatal care.
- Mexico: Participatory workshops on gender issues.
- Nicaragua: Sexual and reproductive health services in the army.
- Nigeria (Conscientizing Male Adolescents): Encouraging male adolescents' critical thinking about gender norms.
- Nigeria (New Society Project): Increasing male concern and participation through a male-focused NGO.
- Philippines: Engaging men in gender advocacy work.
- Thailand: 100% condom-use program.

Brazil

Instituto PROMUNDO is a Brazilian nongovernmental organization (NGO) that has been working to promote sexual and reproductive health among adolescent males since 1998. PROMUNDO specializes in research, training, policy advocacy, and implementing community-based interventions. PROMUNDO’s work is mainly centered on community support for children, youth, and families; gender, health, and adolescence; violence prevention, including gender-based violence; and support for children and families affected by HIV/AIDS. PROMUNDO’s approach includes integrating gender specificity (that is, identifying needs of male adolescents based on socialization) and gender equity into its programs.

The organization has several ongoing projects that work with young men. The Guy-to-Guy Project is an example of a community-based project that recruits and trains young males to be peer promoters for reaching other young men. Based on the results of baseline research, the program was designed to use peer promoters to communicate relevant issues using educational materials; a condom social marketing strategy; publication of a lifestyle magazine emphasizing gender equity; and plays about gender-based violence prevention and male involvement in sexual and reproductive health. An example of PROMUNDO's work in training is Project H: Working with Young Men in the Promotion of Health and Gender Equity. Project H is a training manual and video set for health professionals that consists of five modules on sexual and reproductive health, mental health, violence prevention, fatherhood and caregiving, and HIV/AIDS. PROMUNDO conducts regional and national training workshops on using the manuals throughout Central America, Mexico, and Brazil, among other regions,. PROMUNDO's advocacy work includes launching the White Ribbon Campaign in Brazil to engage policy makers and men in the fight against gender-based violence. PROMUNDO has also conducted research on young men, sexual and reproductive health, and gender-based violence. It is in the process of conducting a two-year evaluation of its gender-equity projects to determine their impact on attitudes and behavior changes among men.

Lessons Learned

- Developing and maintaining partnerships with other NGOs and governmental organizations is essential.
- Although the process can require a lot of time, it is an important investment for ensuring success and significant impact.
- Engage young adolescents by focusing on multiple issues that affect their daily lives.
- Combine research with practice. Designing programs that are evidence-based offers more credibility at the policy level. Furthermore, dissemination at the national level has contributed to other organizations adopting ideas and findings.
- Focus on the potential of male adolescents and not their shortfalls. When addressing sexual and reproductive health and gender-based violence prevention, it is important to engage men as the solution. As a result, the potential of men to be engaged, respectful, and nonviolent partners can be achieved.

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Information adapted from Barker, G. "Instituto PROMUNDO: Engaging Young Men in Gender-Based Violence Prevention and Sexual and Reproductive Health." Presentation at Oxfam workshop, Gender Is Everyone's Business: Programming with Men to Achieve Gender Equality, England, June 2002. Available at: www.oxfam.org.uk/what_we_do/issues/gender/gem/downloads/Promcase.pdf.

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India: Central Himalayas

SIDH (Society for Integrated Development of Himalayas) is a nonprofit organization that focuses on education as a means of addressing gender inequities in the villages of the Central Himalayas. SIDH has developed an innovative training strategy for village youth that views gender as part of the larger issue of social injustice and explores the relationship of gender equity to men's and women's reproductive health. SIDH's holistic approach acknowledges that gender equity and reproductive rights are deeply rooted in the cultural and traditional values of communities and therefore cannot be considered in isolation.

SIDH's work on gender issues grew out of several years of experience working with women's groups. SIDH staff realized

that most of their programs with women did not fully succeed because of lack of support from the men in women's lives. SIDH felt that a genuine attempt must be made to enroll men in women's issues, both to ensure that efforts to empower women did not adversely impact the lives of women and their families as well as to help liberate men from the social pressures of sex-role stereotypes.

Through a series of workshops, focus groups, and interviews, SIDH gathered information from men, women, and youth in selected villages about their beliefs, customs, and values, related to gender relations. They also conducted a detailed exploration of reproductive health issues, as well as caste and class aspirations. Selected findings include:

- Both men and women said that health was a major problem, though most of the other problems identified by the two groups were different (problems identified by the men were mostly to do with infrastructure, like lack of roads or transport, and women's problems were linked to those around their daily lives, such as untethered animals eating their produce).
- Health problems of women increased after marriage. Usually women had problems of white discharge and men had problems related to urinary infection.
- The most significant finding was the extremely high infant mortality rate.
- Women knew very little about their health problems and men's health problems; men had much more information about their own and women's health problems.
- Women and men adhered to a variety of prenatal and postnatal beliefs and practices (such as a pregnant woman must work hard and eat less to have less pain during childbirth and that male children are more fragile and need to be breast fed twice as much as girl children).
- Both men and women support family planning and appropriate birth spacing; men feel that more children mean extra expenses while women feel they create extra work. There is knowledge of pills, IUDs, and condoms, but the "operation" (female sterilization) is seen as the only safe family planning method (though many women believe it ruins women's health). Women are not in favor of using condoms because it deprives them of the "shakti" (power) they get from the man's sperm.
- Priorities and access to health care are different for each sex. Men, who are more mobile than women, go to the marketplace or nearby town and are able to visit the doctor at the first sign of ill health. Women must be accompanied by their husbands to visit a doctor. Traditionally, it is believed that women are able to bear more pain, and are taken to the doctor only in extreme conditions.
- The local word for husband is "malik"(owner). "Our husbands own us. We must do as they say". Women feel that men are incapable of demonstrating affection. "They are made that way by God, just as women are made to love."
- Most of women's work is invisible with no tangible result, therefore it is not valued. "The wood and fodder a woman gathers has more value than cleaning, tending children, cooking, as it can be seen and measured. When I come home with a big bundle of grass on my back it can be seen and I am treated with respect and my mother-in-law rushes to me with a glass of water or tea. That is why I prefer working outside the home, where my work is seen".

Using these and other findings from their research, SIDH staff set about the challenging task of designing a training module on gender issues, including reproductive health. The training is designed to change social attitudes rather than to impart knowledge and/or a particular skill. In the training module SIDH attempts to sensitize participants toward their blind spots and prejudices and invoke their sense of justice. SIDH believes that this in turn will pressure them from within to become more responsible toward women and their reproductive health issues. The training is designed for youth as, in SIDH's experience, they are most receptive to new ideas and most capable of making lasting changes in their attitudes and behaviors.

SIDH's workshop curriculum takes a step-wise approach to introducing the sensitive issues related to gender and reproductive health. The first day focuses on objective information, such as the difference between "gender" and "sex" and statistics and case studies that illustrate gender discrimination. The second day goes a step further to reach the participants at a deeper emotional level, using popular idioms, songs, and films. Only on day three are participants exposed to direct information about reproductive health issues. On the fourth day, participants make "Personal Work

Plans" to help them follow up on their workshop experiences after they return to the village routine.

To date, SIDH has conducted 12 workshops involving about 250 rural youth from 42 villages. At the end of these 4-day workshops, there was much more interaction between women and men. Women spoke more and were more animated, challenging the men and voicing their opinions more than they had done at the beginning of the workshop.

SIDH has found that the change in participants' personal lives is most visible in married men. The case of Gulab, a participant who had been married for ten years, provides an interesting example. Despite many opportunities to work near his home, he preferred to be away from his family, as he could not cope with the number of complaints from his wife. After the training he confessed that he had never realized how cruel he had been to his wife. He decided to move to his home even though it meant taking up a less desirable job. His wife now appears to others to be happy and relaxed, and those who know her are surprised to see her smile. The change is also visible in Gulab. He too looks happy and has become far more energetic in his work place.

Lessons Learned

- A holistic and integrated approach is essential. Change cannot be compartmentalized. Hence gender and reproductive health issues need to be seen in the larger context of social injustices.
- Beliefs are culture-specific and need to be challenged within the cultural context. Hence identification of beliefs through research is essential.
- Lasting change is possible only if the cluster of beliefs and attitudes impacting gender discrimination are identified and information provided that conflicts or creates dissonance with these beliefs. The assumption is that this conflict or dissonance will lead to change, or a shift in attitude.
- Gender justice is about healthier relationships at the micro-level. Hence men's involvement is important for the sake of both justice and happiness.
- Making the training modules non-threatening and empathetic to men is important, as the goal is to involve men, instead of making them defensive. Male facilitators are important to this objective.
- The training needs to focus on attitude shift, rather than just imparting information. Attitudes of both participants and trainers need to be challenged.
- Participants' enthusiasm diminished approximately one month after the initial training. Fear of alienation, isolation and ridicule are the biggest obstacles to maintaining new attitudes and behavior change in these Indian villages. Broader training programs are important so that the participants would not be in the minority and would have peers and/or family members who would support them. Other means of post-workshop support should be explored.
- A strong commitment on the part of the organization and the trainers to gender equality and involving men in women's reproductive health is required, as well as a capacity for reflection and flexibility.

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India: Gujarat State

Sewa Rural operates in a poor, largely tribal region of Gujarat State. Their experiences in attempting to include men in women's health include a safe motherhood initiative, a program for newly married couples, and distinct family planning and adolescent health awareness programs. Between 1993 and 1995, Sewa Rural revised their approach to maternal care, seeking to involve men and other family members in preparing for safe childbirth by supporting women in registering

early, obtaining adequate nutrition, planning ahead for delivery, recognizing signs of complications, and taking appropriate action in response.

To remind pregnant women and their families of the anticipated delivery date, the date is inscribed on the walls inside the family home, using appropriate reference to local calendars. Sewa Rural also uses a postcard system to inform families of the expected delivery date (reminders are sent to the expectant mother's home as well as that of her parents where many women opt to deliver, especially for first-time pregnancies). Postcards also are used to remind families of impending doctor's appointments or special care prescribed in abnormal circumstances.

The safe motherhood initiative also involves field visits that are tailored to men's schedules. The initiative's overall success is evidenced by the 40 percent increase in men seeking out health workers to register their wives for early antenatal care, a one-out-of-three rate of men accompanying their wives for visits to the hospital, and a significant increase in the number of fathers who have started bringing their young infants for immunization.

Less encouraging are observations that men, family members, and women themselves continue to believe that a man must not be present during his wife's labor. Also, all family members, including women, are reluctant to have men donate blood for their wives—even in critical situations—for fear that this will physically weaken the husband.

A program to initiate rapport between Sewa Rural health workers (male and female) and newly married couples has also been started. It consists of meetings that attempt to organize discussions with the couple alone, as well as with the couple joined by their elders. In addition to various information, education, and communication (IEC) materials, newlyweds are also provided with a Sewa-Rural gift pack containing trinkets and an appropriate gender-specific sample contraceptive (condom for men, regimen of oral pills for women).

Lessons Learned

- Early rapport between health workers and newlyweds was deemed of great importance. Once established in the community, capable health workers who effectively manage ailments ensure active participation and utilization of services by both men and women.
- In their adolescent health and awareness initiative, Sewa Rural has found that multiple, ongoing, and continuing sessions with the same group, over a period of time and covering a few topics per session, are most effective.
- Male and female health workers play an important role in motivating couples and often become role models that help establish healthier reproductive habits in the community. Male health workers in particular assist in motivating male members of the community and are vital in adolescent groups.
- Health and well-being need to be approached in a holistic manner in which the family is seen as a unit and a comprehensive package of health services is delivered. In addition, the underlying fabric of socio-cultural traditions and the economic milieu has to be kept in mind while introducing any such strategy.

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Information adapted from Population Council/India, Draft Report (1999).

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India: Nandesari

The Pati Sampark ("meeting husbands") program of the Deepak Charitable Trust is an effort to involve men in antenatal care. The program is part of a larger World Bank funded national program to promote a small-family norm by supporting

safe motherhood and childbirth practices in India.

The Pati Sampark program is being implemented in Nandesari, an industrial area 20 kilometers north of Baroda, India. The population is primarily Rajput, which is characterized by conservative and restricted roles for women. The program was started in 1995 in response to low attendance by high-risk women at monthly antenatal clinics. It eventually was expanded to include all pregnant women, regardless of risk status. The program is implemented by both male and female outreach workers as well as trained midwives. It aims to motivate husbands to monitor their wives' clinic attendance and consumption of the iron and calcium supplements at the prescribed times. It was hoped that by incorporating husbands into an existing antenatal service delivery program, attendance at antenatal clinics would rise and the incidence of low birthweight babies would fall.

When the program started, male outreach workers visited the husbands of pregnant women who were not attending monthly antenatal clinics. The outreach worker spoke to the husband about the importance of antenatal care, specifically (1) tetanus toxoid vaccination, (2) hemoglobin testing, (3) blood pressure checks, (4) a proper diet, (5) iron and calcium supplements, and (6) safe childbirth. Men whose wives were identified as having high-risk pregnancies also were given information on the various symptoms of a high-risk pregnancy and appropriate treatment. All men also were given information about family planning methods and the benefits of spacing children at least three years apart.

The Pati Sampark program did influence the degree of attendance at antenatal clinics. An evaluation of the program found that while many women attended the clinics two to three times during their pregnancy, women whose husbands had participated in the program were more likely to attend the clinics on a repeated basis (6 to 7 times) than were women whose husbands did not participate. The program also succeeded in raising men's awareness of their wives' use of antenatal services (including vaccinations, routine tests, and supplements). Men who participated also reported a greater awareness of various contraceptive methods and the benefits of child spacing.

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Information adapted from Dev, A. *Involvement of Husbands in Antenatal Care: Evaluation of Deepak Charitable Trust's Outreach Program*. Baroda, India (1998).

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Mexico

Salud y Género (Health and Gender) is an organization which aims to contribute to a better quality of life and health for women and men through activities in the areas of mental, sexual, and reproductive health. It serves various rural and urban sites throughout Mexico. Salud y Género grew out of efforts to address the physical and mental health issues of women displaced by the 1985 Mexico City earthquake and Guatemalan refugees in Southern Mexico. During the course of this and subsequent work, the need to include men in the discussion of health issues became apparent.

A Participatory Approach

Over the past few years, having built expertise through working with women, Salud y Género has been conducting participatory workshops that encourage men to explore traditional gender role expectations and the influences these expectations have on men's relationships with their partners, families, and communities. Each workshop lasts two to three days. Most are for men only, though some involve both men and women as participants. Salud y Género has held workshops for interested men from the community, secondary school youth, men in prisons, staff and volunteers from

health and development organizations, public sector teachers, and staff and volunteers working in health promotion among indigenous groups.

Each workshop includes a variety of activities designed to encourage participants to reflect upon their experiences and perspectives related to gender issues. Examples of these activities include:

- The Gendered Body: Participants draw the male and female body and make a list of the cultural characteristics attributed to men and women. They also list the health problems that are common in men and women and use this as the starting point for a discussion of the gender bases of health.
- The Time Tunnel: This exercise asks participants to review their life stories, with attention to gender roles that were presented to them in their families. Using these recollections, participants develop collages and share the images of the persons, institutions, and experiences that have influenced them the most.
- Management of Emotions: Men discuss five basic emotions (fear, affection, sadness, anger, and happiness) and the social constraints that men feel in terms of how they can or cannot express these emotions.
- Violence in the Couple: Participants discuss expectations in male-female relationships, manifestations of violence, and ways to detect and react to feelings that could or have led to violence against one's partner. A related exercise allows men to look at the various ways that anger can be expressed and explore ways of managing it.
- Images of Fathers: Participants talk about images of their own fathers and the feelings they have related to the presence or absence of their fathers in their lives.

Challenges and Lessons Learned

- Viewing masculinity as a risk factor is an important and non-threatening starting point for discussion of issues related to sexuality, health, and intimate relations.
- Discussing gender and masculinity is not possible at an institutional level until the individuals involved have first reflected about their own values and realities related to gender.
- While involving individual men is important, expanding outreach to institutions is an important way to access larger groups of men. Salud y Género is in the process of developing training materials to accompany its workshops and implementing a "multiplier" strategy, which seeks to reach men affiliated with organizations or institutions who can then replicate the workshops for others.
- Women can play an important role in encouraging men to participate in gender-related workshops.
- A two-workshop series is generally needed to allow men time to process the ideas discussed and develop skills to facilitate future workshops.
- Activities to address gender issues should start with a clear idea of desired outcomes and indicators to measure success in achieving these outcomes.
- Awareness-raising activities, such as radio spots and public education about gender issues, are helpful in creating a positive environment for workshops and recruiting participants.

Adapted from IPPF/RHO and AVSC 1998.

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Nicaragua

This UNFPA-supported project trained the Military Medical Corps of the National Army of Nicaragua to provide information, education and communication (IEC) on sexual and reproductive health. The overall purpose of the project was to improve men's and women's access to reproductive health and family planning services.

The project had two components: training and education for military personnel in reproductive health/family planning and service delivery. The Military Medical Corps of the National Army provides health care services to army members and their dependents. This project aimed to strengthen the quality of health care within the army and addresses the shortage of public health services by providing primary health care, IEC, and reproductive health care to communities surrounding military units.

The project promoted the concept of sexual and reproductive health as a human right. Doctors, nurses, and nurses auxiliaries were trained to integrate reproductive health/family planning services into primary and secondary health care offered by military health units. One thousand soldiers and officers were trained to carry out information and sensitization activities on reproductive health and sexual rights. Educational material produced by the Nicaraguan Community Movement was adapted for use in reproductive health and IEC activities.

The Military Medical Corps developed a working relationship with several government and non-government reproductive health projects. For instance, the Center of Information, Services and Counseling on Health (CISAS) and the Nicaraguan Community Movement worked with the Medical Corps to train health leaders and promoters in reproductive health and family planning.

Results

- Army commanders, officers, and soldiers became much more aware of the various issues related to sexuality that need to be addressed, particularly STI prevention, and gender-based violence.
- Military personnel, men, and women, were sensitized about reproductive health, family planning, and gender equity.
- During the post-Hurricane Mitch reconstruction and rehabilitation period, military health teams working in the disaster zones provided reproductive health and family planning information, and distributed oral contraceptives and condoms.

Lessons Learned

- The Military Medical Corps and army are effective mechanisms for reaching large number of men, including male adolescents.
- The army can become a provider of quality service delivery to rural populations who have little access to information and services.

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Information adapted from: "Support to reproductive health activities of Nicaraguan Army". UNFPA Project Nic/97/PO4 (1997).

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Nigeria (Conscientizing Male Adolescents)

The Conscientizing Nigerian Male Adolescents (CMA) program was established in 1995, with funding from the International Women's Health Coalition. The program aims to teach and encourage Nigerian male adolescents, ages 14 to 20, to develop a critical awareness and abandon sexist prejudices and practices. The program includes a curriculum that focuses on various topics while taking cultural norms into consideration. Among the topics included are Nigerian society, women's roles and family structures, sexuality, reproductive health and rights, and violence against women.

At its inception, the program started with 25 participants that met on a weekly basis for a 9-month period. The adolescent males convened each week to discuss, debate, question, and analyze issues related to reproductive health, violence, gender equity, and human rights, among other topics. They focused on creating a dialogue, led by adult facilitators, which enabled the adolescents to explore their attitudes, beliefs, and values with respect to the program topics. As a result, the participants became better equipped to think independently and analytically.

Based on findings of the first-year evaluation, CMA added a second year to the program. In 1999, the two-year program grew to 100 participants. The first year of the program continued to include the weekly dialogues. A second year was added to conduct monthly meetings to reinforce what had previously been learned. Since then, CMA has expanded by adding a peer-education practicum, an outreach program, and a training manual/curriculum guide.

In upcoming phases of the program, several initiatives will be implemented, thereby, maximizing and extending its benefits. One such initiative is the establishment of CMA discussion groups in several Calabar postprimary and secondary schools, as well as in a neighboring state. Additionally, there are plans for CMA's newsletter, *The Male Adolescent*, to be disseminated more broadly to reach a wider audience of schools. Ultimately, Dr. Madunagu, CMA's founder, hopes to replicate the program in several other locations so that it has a greater effect on changing the entire society.

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- Conscientization is fundamental; mobilization needs to occur from the roots.
- Challenging the attitudes of teachers and parents will take time.
- Do not set goals that are out of reach; aim for identifiable changes.

Information adapted from Irvin, A. *Taking Steps of Courage: Teaching Adolescents about Sexuality and Gender in Nigeria and Cameroun.* New York: International Women's Health Coalition (2000). Available at: www.iwhc.org/index.cfm?fuseaction=page&pageID=71.

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Nigeria (New Society Project)

Nigeria's New Society Project (NSP), a male-focused NGO established in 1997, is an initiative by men aimed at increasing male concern and participation in sexual and reproductive health in a positive and supporting way, while promoting gender equity in family and society. NSP also promotes the sexual and reproductive health and rights of boys and young men through education and increased access to health services and information.

While many programs have addressed men's and women's sexual and reproductive health and rights through responses that are largely behavioral or cultural, NSP's holistic approach recognizes that it is critical to address a range of structural factors that shape sexual and reproductive health. Therefore, NSP's innovative training programs consider not just the underlying issues of culture and how it shapes men's and women's behavior, but also the range of structural factors, including socioeconomic and power relations between women and men, that create a climate of social inequality and injustice, which in turn affects sexual and reproductive health and rights.

In Nigeria, several intervention programs address women's vulnerable position in sexual relationship with men and seek to empower women. Many of these program have lacked support from men who see women's empowerment as a threat to their power. Some men may maintain these views because they have not been exposed to programs that encourage an ideological shift.

NSP believes that in a male dominated, patriarchal society like Nigeria, the support of men for women's empowerment and for their sexual and reproductive health is critical. NSP therefore seeks to involve men in exploring the influence they have on their own health and the health of women, and to increase men's support for women's sexual and reproductive health and rights and the well-being of their children.

Social mobilization strategies that engage men as active change agents are central to generating change in societal attitudes, beliefs, and gender stereotypes, and in redefining male-female relationships and roles. Through its innovative and dynamic programs, NSP is working to promote the emergence of a new, nationwide men's network to address sexual and reproductive health and rights problems—a prevailing phenomenon in Nigeria.

Already, NSP has stimulated the creation of a men's group called Men's National Network for Reproductive Health (MNNRH), which currently has chapters in six of the 36 states of Nigeria, and the Young Men's Health Network (YMHN) for boys and young men in schools. These networks include male individuals and groups in their reproductive and childbearing years across the nation who are beginning to question masculine violence, confront patriarchy and authoritarian culture, and serve as active change agents in their respective neighborhoods, villages, and communities.

Over the past few years, NSP has been conducting seminars, workshops, and training programs that encourage members of the networks to explore how gender is related to sexual and reproductive health by addressing beliefs, cultural norms, societal expectations, roles, status, power relations between women and men, and sexuality. These workshops and meetings provide opportunities for members of the network to discuss and exchange observations on their lives as men, re-educate themselves, and bring about transformation of their personal practices and behaviors. To date, 1,200 men and adolescent males have joined these networks across the nation and participated in NSP's organized activities. NSP is also reaching out to new members men through various institutions, and is developing a center for Research on Men's Health and Social Behaviour. NSP and its participants hope that these networks will take root in all 36 states of the federation.

Lessons Learned

- Traditional male dominance is a major obstacle to promoting the much-needed social change in sexual and reproductive health and rights. Male factors are so dominant in harmful practices like marriage of adolescent girls, poor birth spacing, large families, polygamy, unsafe motherhood,and other reproductive health problems.
- Nigerian men usually go to traditional herbalists when they decide to seek out services for reproductive health issues. Without increased education, men will continue to consult non-professional providers for services, thereby placing themselves and their partners at risk of infection.
- Men themselves must become active change agents. New men's groups should be encouraged to create fora for men to re-educate themselves and to confront patriarchal, authoritarian, and violent elements in the culture.
- Promoting behavioral research is important in addressing men's sexual and reproductive heath.
- Ensuring that sexual and reproductive health education includes gender analysis and emphasizes the right of men and women to sexual equity and equality is important.
- Access to health care services is essential to ensure effective treatment.
- Since schools help to reinforce gender stereotypes, reaching out to boys and young men in schools is important.

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Philippines

Harnessing Self-Reliant Initiatives and Knowledge, Inc. (HASIK) is a nongovernmental organization (NGO) in Quezon City in the Philippines. HASIK uses a participatory approach to provide services to poor communities and sectors. HASIK's approach empowers communities and sectors through organization of the urban poor, gender advocacy, early childhood care and development, livelihood development, research and documentation, and the development of creative training methodologies for skills-building and consciousness-raising seminars.

For over 11 years, HASIK has been carrying out a project entitled Gender Seminars for Men (GSM). The GSM project is a module developed for men to increase awareness around gender issues. The goal of the project is to make men allies in gender awareness as well as to minimize the barriers to achieving gender equity. The module uses participatory learning techniques and emphasizes establishing effective commitment coupled with cognitive awareness. The module is made up of six phases: Setting the Scene; Hearing Women's Voices, Feeling Women's Pain; Articulating Women's Issues; Visioning a More Desirable Future; Committing Oneself; and Acting on Commitments.

There has not been a formal evaluation of the GSM; however, empirical results indicate that the project has been successful. HASIK receives numerous requests from institutions interested in participating in the seminar as well as personal testimonies of the participants' positive experiences.

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Information adapted from Cruz, M.S. "Deciding to Dance: HASIK's Experience with Men in Gender Advocacy Work." Presentation at Oxfam workshop, Gender Is Everyone's Business: Programming with Men to Achieve Gender Equality, England, June 2002. Available at: www.oxfam.org.uk/what_we_do/issues/gender/gem/downloads/HASIKcase.pdf.

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Thailand

The Ministry of Public Health in Thailand started "The 100% Condom Program" in 1989 as a way of addressing high rates of sexually transmitted infections, including HIV/AIDS. Participation in the program became mandated by the government in 1991. The program's main audience is men who are clients of sex workers. The goal of the program is to achieve 100% condom usage during all commercial sex. Since many Thai men visit brothels, a reduction of STI/HIV from this source will significantly protect their wives or girlfriends as well as protect the sex workers.

The campaign uses three main strategies:

- A mass television and radio campaign encouraging men to use condoms during commercial sex
- Providing a continuous supply of free condoms to sex workers and sex establishments
- Promoting and enforcing universal condom use at commercial sex establishments

If a client refuses to use a condom, the sex worker refuses to have sex and refunds the client's money. If a client contracts an STI and presents at a government STI facility for treatment, clinic staff ask where he may have contracted the disease. The sex establishment is then contacted regarding compliance issues. Establishments that fail to comply with the 100% condom program are shut down by the police.

Impact

The program appears to have had a significant impact on changing condom use and reducing STI rates among the intended audience, though other concurrent STI/AIDS prevention activities also may have contributed. Reported condom use in sex establishments increased from about 14% in 1989 to more than 90% in 1994. During the same time period the STI rate decreased by more than 85%. A study of HIV incidence rates among military recruits in Northern Thailand found that HIV incidence declined from 2.48 per 100 person-years during 1991–1993 to 0.55 per 100 person-years during 1993–1995 (Celentano et al. 1998). This dramatic decline is attributed in large part to the 100% Condom Program.

Lessons Learned

The program has been successful because it:

- focuses on a limited goal (use of condoms during commercial sex);
- builds upon an existing strong STI prevention program, which includes maintenance of sex establishment rosters, good availability of STI services (including for sex workers), and contact tracing of STIs to sex establishments;
- provides an unlimited supply of free condoms;
- applies to all sex establishments nationwide, so that customers do not have the option of seeking "condomless" sex elsewhere (thereby not threatening the income of sex workers or sex establishments); and
- enlisted the cooperation of the government and has a mechanism for enforcement.

For more information, please contact:
Department of Communicable Disease Control, Thai Ministry of Public Health, Bangkok, Thailand

Information adapted from Rojanapithayakorn et al. 1996.

Interagency Gender Working Group (IGWG) Men and Reproductive Health Task Force

The Interagency Gender Working Group (IGWG), established in 1997, is a network of NGOs, including the United States Agency for International Development (USAID) Cooperating Agencies (CAs), and the Center for Population, Health and Nutrition (PHN) of the USAID. The IGWG promotes gender equity within PHN programs, in order to improve Reproductive Health/HIV/AIDS outcomes and foster sustainable development. (For more information about the IGWG, please see their website at: www.igwg.org/.)

As part of a restructuring within the IGWG, the Men and RH Sub-Committee has been changed to the Men and RH Task Force, which is charged with organizing a global conference in September 2003, "Reaching Men to Improve Sexual and Reproductive Health of All." Additional information on this conference will be posted here during a future update.

- Overview
- Core values
- Key activities, themes, and products
- Meeting minutes
- For further information

"Special efforts should be made to emphasize men's shared responsibility and promote their active involvement in responsible parenthood, sexual and reproductive behavior, including family planning, prenatal, maternal and child health; prevention of sexually transmitted diseases, including HIV; (and) prevention of unwanted and high-risk pregnancies…"—Programme of Action, International Conference on Population and Development ,1994.

Overview

In 1996, in response to global action plans adopted at the Cairo and Beijing conferences emphasizing that men's shared responsibility was essential to improving women's health, USAID's Office of Population commissioned a survey to provide information about the extent and nature of men's involvement in its family planning and reproductive health

programs. The report, "Involving Men in Reproductive Health: A Review of USAID-funded Activities," indicated that USAID cooperating agencies (CAs) lacked clear guidance on the priority that they should place on this issue, and needed models on how to integrate men into existing programs in a way that enhanced services to women. Recommendations included that USAID should provide direction on cost effective and gender-sensitive approaches to reaching men, ensure universal availability of condoms, and give higher priority to information and services for young men.

In 1997, the Office of Population convened the Interagency Gender Working Group (IGWG), with broad participation from CAs, donors, and other individuals and agencies working in the field of reproductive health. Four subcommittees were formed: Gender and Policy, Research and Indicators, Program Implementation, and Men and Reproductive Health. The Men and Reproductive Health Subcommittee meetings are held quarterly, and are attended by about 35 individuals representing 20 organizations.

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Core values

The core values of the Men and Reproductive Health Committee are:

- To promote women's empowerment and gender equity, particularly concerning reproductive health;
- To increase men's support for women's sexual and reproductive health and children's well-being; and
- To promote the reproductive and sexual health of men and women.

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Key activities, themes, and products

- To help institutionalize men's positive participation in reproductive health;
- To provide a forum for ideas, networking, and information exchange;
- To improve knowledge of best practices on men and reproductive health;
- To advise USAID and agencies interested in men and reproductive health; and
- To monitor projects funded by our committee.

Priority Themes

The Subcommittee has agreed to focus on three priority themes for the next two to three years:

- meeting the needs of adolescent boys
- dual protection (see IGWG statement)
- gender-based violence and reproductive health

Products

The Subcommittee has given small grants to produce these products:

1. Implementation Guide on Reaching Men to Improve Reproductive and Sexual Health. Completed in 2004, this guide captures the programmatic issues discussed at the Reaching Men to Improve Reproductive Health for All international conference held in Dulles, Virrginia, September 15–18, 2003. The guide is available online at www.

jhuccp.org/igwg/guide/index.html or can be ordered on CD-ROM at www.hcpartnership.org/Publications/.

2. CD-ROM (Entitled Helping Involve Men, HIM). A resource for developing countries, with 11,000 pages of full-text documents on men's roles, programs and research. A second distribution of 1,000 copies was completed in 2001. (Johns Hopkins University Communications Program, JHU/CCP).
3. Website. The Subcommittee supported the Men and Reproductive Health section of this Reproductive Health Outlook website.
4. The Arabic edition of *Network* 18(3), Men and Reproductive Health, published Spring 1998. Available at: www.fhi.org.) A 44-page resource for Arabic health providers and policy makers. 10,000 copies circulated in Arabic-speaking regions in 1999. (Family Health International).
5. Men and Reproductive Health Orientation Guide. A training workshop on the rationale for men's involvement in family planning, STI/HIV prevention, safe motherhood, and fatherhood, and on the socialization of adolescents and gender-based violence (FHI and Margaret Sanger, International). All the materials for this training workshop, Involving Men in Reproductive Health: A Guide, are now available on CD-ROM in English or Spanish; click here for the PRB order form, or contact prborders@prb.org.
6. Provider Training Curriculum. Partial funding for a comprehensive curriculum that EngenderHealth is developing to train service providers to involve men and address men's own reproductive health needs. The curriculum will comprise three sections. The first is on organizational and attitudinal issues related to MRH services and is currently available, but not yet online. Sections two and three are being developed. (Engender Health, for more information contact mmehta@engenderhealth.org).
7. Indicators for Programming—Men and Reproductive Health. Available at: www.measurecommunication.org. Illustrative performance indicators for monitoring and evaluating male involvement programs. Contact nyinger@prb.org.
8. *Three Case Studies: Involving Men to Address Gender Inequities.* Available at: www.measurecommunication.org. This publication presents case studies that highlight three programs and their approaches to working with men to improve reproductive health for all.

Currently, working teams are developing case studies on dissemination and evaluation of the above products and on outreach and advocacy, particularly in the areas of adolescent boys, dual protection, and gender-based violence. Meetings, which take place in the Washington, DC , area, are open and new members are encouraged to participate.

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Meeting minutes

For more information, please review the minutes of past Subcommittee meetings:

- May 2000
- August 2000
- November 2000
- July 2001
- November 2001
- February 2002

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For further information

For additional information, please contact the IGWG chair, Victoria Jennings (jenningv@georgetown.edu), or the IGWG

coordinator, Diana Prieto (dprieto@usaid.gov).

Page created December 2001; updated October 4, 2004.

IGWG Men and Reproductive Health Subcommittee

Meeting Minutes: May 25, 2000

- Attendance
- Project updates
- Presentations
- Priority setting
- IGWG dissemination plans
- Plus-Delta exercise
- Next meeting
- For more information

Attendance

Elaine Murphy/PATH, Karin Ringheim/USAID, Josselyn Neukom/PSI, Alfred Yassa/JHU, Carol Sienche/JHU, Amy Weissman/Save the Children, Patrick Lemmon/MRPP, Meg Greene/CHANGE, Jeff Spieler/USAID, Mihira Karra/USAID, Martine de Schutter/PAHO, Jill Gay, Mary Nell Wegner/AVSC, Erin Anastasi/IRH, Ellen Weiss/ICRW, Chinwe Machibuike/CEDPA, Diana Santillan/URC, Caroline Quijada/URC, Justine Sass/PRB, Bill Finger/FHI, Tim Williams/JSI, Jim McMahan/PRIMEII, Bessie Lee/USAID, Audrey Seger/USAID, Sam Clark/PATH, Michele Burger, Nick Danforth, Judith Helzner/IPPF, Jodi Jacobson/CHANGE

The Men and Reproductive Health Subcommittee has a new co-chair, Sam Clark from PATH, replacing Bill Finger from FHI who rotated off after two years as co-chair. Thank you for all your hard work, Bill! The Interagency Gender Working Group, IGWG has a new coordinator, Audrey Seger from the Policy & Evaluation Division. Michal Avni is on maternity leave until September.

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Project updates

Dr. Alfred Yassa, Johns Hopkins University Center for Communication, Jordan Project: "Together for a Happy Family"
In 1996, JHU started researching assumptions and opinions about family planning. Results indicated that the husband played the principal role in decision-making, that unmet need was estimated at 25 percent, 20 percent of non-user's cited husband's opposed family planning, and that religious teachings were the primary determinant of opposition because 80 percent of men were uncertain of the morality of family planning or Islamic sanctions against family planning. To address these assumptions, JHU developed innovative approaches. First, they met with and involved religious leaders, social workers and physicians in family planning project planning. JHU also used the Royal Family's endorsement in their communication projects and finally developed recreational activities to promote family planning. These communication approaches have been successful in part because they involved men in addressing traditional assumptions against family planning. For more information contact Alfred Yassa (ayassa@jhuccp.org)

Erin Anastasi, IRH, Georgetown University, Water & Sanitation Program
Erin Anastasi made a presentation on IRH coordination with PSI and the El Salvador Water and Sanitation Program, IRH has been working on family planning education and referral system using the "Standard Days Method." This is a new method of counting days of a women's menstrual cycle to determine the most fertile days for which to practice abstinence. IRH has developed a new model of instruction that includes male participation in counting days and participating in monitoring fertility. The project is designed to evaluate two approaches, one with in-depth participation of husbands and one without. For more information contact Erin Anastasi (anastase@gutnet.georgetown.edu)

Martine de Schutter, PAHO, New Men's Involvement Program
Martine de Schutter, of PAHO, made a brief announcement about the launch of a four-year Men's Involvement project in seven Central American nations (Belize, Costa Rica, El Salvador, Honduras, Guatemala, Nicaragua and Panama). Two demonstration projects will be established within each country. They plan to start with a baseline research gap assessment over a period of 1.5 years to help in developing two models to use in involving men in reproductive health programs and developing a document about changing norms. PAHO will work with governments to encourage them to with work with existing groups and programs when planning their educational strategies. For more information contact Martine de Schutter (schutterm@paho.org) .

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Presentations

Freya Sonenstein,Director, Population Studies Center, The Urban Institute
"Recommendations and Strategies from the Working Group on Enhancing Young Men's Reproductive Health"
Freya presented the recommendations from a two-year effort (supported by the U.S. Federal Title X Office of Family Planning) by a working group of 20 experts drawn from adolescent medicine, reproductive health and family planning, public health, community organization and youth development. The working group has drafted a report for DHHS to promote consensus on the goals and content of young men's reproductive health promotion in the United States, identify strategies, and make recommendations for program initiatives.

The policy arena is now open to men's involvement in reproductive health for several reasons: new welfare legislation requiring paternal support, a movement to promote fatherhood, new pressures on existing services, such as HIV/AIDS/STI prevention, and better, nationally representative data on young men's reproductive health. The recent trends about young men's reproductive health are positive, but there is continued risk-taking and a continued lack of access to information and services, particularly for young men. Reported condom use by young men at last intercourse doubled between 1979 and 1988 and increased significantly between 1988 and 1995 from 57 to 66 percent. During the period from 1988 to 1995 there was a significant drop in the proportion of young men reporting ever had sexual intercourse

(from 76% to 68%) and an increase in formal reproductive health education prior to first intercourse. While a high percentage of young men report a physical exam in the last year, most of these visits failed to address reproductive health issues. Findings vary greatly based on race and ethnicity, risk-taking remains high and there is an inverse relationship between condom use and age. A major issue in young men's reproductive health is that even though services or information may be available, generally young men don't take advantage of services because they perceive family planning program to be for women's empowerment and not friendly to men.

Given the emerging consensus to involve men two key questions remain: How to attain this objective (What would programs look like) and How to pay for it? The working group developed five goals: 1) developing a holistic approach to promoting sexual health and development, 2) promoting healthy intimate relationships, both sexual and non-sexual, 3) preventing STIs/HIV, unintended pregnancy and 4) promoting responsible fatherhood. Each of these goals is to be addressed with a strategy that 1) conveys needed information, 2) fosters skills development, 3) promotes positive self-concept, 4) promotes positive values and motivation, and 5) provides access to clinical care as needed. The working group recommends improving young men's access to services through an interagency community approach. In their forthcoming report, they will present a comprehensive reproductive health strategy, including an evaluation mechanism, guiding principles, and recommendations, potential sources of funding and a list of indicators for achieving their five goals. In the discussion, Freya emphasized that the issue is not men versus women. We need to empower men to behave in new ways in order to achieve gender equity. A colleague at the Urban Institute has conducted research that indicates that the more men buy into traditional ideology, the more risks they take. We (as societies, cultures) need to redefine how men think of themselves and of manhood.

Patrick Lemmon, Co-Director, D.C.'s Men's Rape Prevention Project
The Men's Rape Prevention Project (MRPP) is a DC-based nonprofit organization that empowers male youth and the institutions that serve them to work as allies with women in preventing rape and other forms of men's violence. More than 50 percent of unwanted pregnancies in the District result from unwanted sex. Through awareness-to-action education and community organizing, the project works with high schools, colleges and other groups to promote gender equity and build men's capacity to be strong without being violent.

The presentation began with a brief discussion of how men in the United States and internationally respond to the idea that they can and must play a role in stopping sexual violence, and the challenges that educators face in attempting to speak to men about these issues. Patrick described the "act" of manhood as always looking over one's shoulder to foresee the next challenge. Men feel a constant pressure to prove manhood. While surveys show that 80 percent of men have felt uncomfortable with things their colleagues have said about women, a tiny percentage have ever said anything to contradict it, because to do so would potentially compromise their masculine persona. The men who disparage women are likely to interpret this as an endorsement.

To warm up the audience, and as one example of how to potentially break through men's initial defensiveness, the group engaged in a brief but vigorous round of sexual calisthenics. Then, the group developed a continuum of harm to efforts to advance reproductive health, examining how attitudes, assumptions, and behaviors (of both the educators and the audiences) may hinder efforts to encourage men to become engaged in healthy choices.

The group considered the following: "trying to get a girl or woman pregnant to prove one's manhood," "believing that sex is a husband's prerogative," "believing that a woman's place is in the home with the children," "directing reproductive health programs solely toward women," "comparing notes on how good a woman or girl is in bed," "believing that girls (but not boys) must wait for marriage to have sex," "using alcohol or other drugs to 'loosen a girl up,'" "refusing to wear a condom," "believing boys and men always want sex," and "staying silent when a man puts a woman or girl down."

The overall message of these different attitudes and behaviors is that somehow sexual responsibility and sexual health are "women's work," beneath the dignity and importance of men's attention. ("I don't commit rape so this doesn't apply to me.") However, by challenging these attitudes and behaviors in ourselves and one another, we can begin to redefine the culture that we have created around sexuality. To end the presentation, Patrick quoted James Baldwin, the African American author, who said, "The most radical step you can take is your next one."

From this exercise, the group moved into a discussion centered on a few questions: "If the social context described in the exercise is the one in which we are operating, what are the program implications? Do any of our current programs reinforce some of the assumptions that we have identified as problematic? Do any of our current program activities challenge the assumptions that we have identified as problematic? What should AID or CAs be doing now, given this discussion? Reinforcing what was discussed after Freya's presentation, we need to change the understanding of what it means to be a man. Men need to be empowered to speak out against violence, beginning with disparaging remarks that devalue women. Jodi Jacobsen of the CHANGE project said that we have a moral and ethical obligation to figure out what reproductive health programs can begin to do, for example about the link between sexual coercion and STDs. Are programs enforcing or reinforcing gender stereotypes? How can programs recognize and challenge the assumptions that clients bring with them, i.e., the husband's prerogative to have sex? These are issues that the working teams must grapple with as they plan work on the theme of violence in the coming year.

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Priority setting

1. Background

The Men and Reproductive Health Subcommittee has been working to identify a limited number of priority areas to focus its work for the past few meetings. A brainstorming session was held in November in which each member identified three personal priorities, and in February, these thematic areas were categorized according to our three core values and further pared down. Although there was broad consensus about the need to focus on adolescents, the remaining two areas were less clear-cut. Due to changing attendance from meeting to meeting, it was thought that an opportunity to weigh in on the three proposed themes and potential other areas could be done by an email survey. A matrix identifying proposed themes and including details for the IEC working team activities and R&E working team activities under each theme was sent out to the Men and Reproductive Health subcommittee in a survey format to firmly identify our priorities. Over e-mail, prior to the meeting, Members of the subcommittee responded to in an e-mail survey from Sam. Members were asked to express their agreement, disagreement or concerns regarding priority themes. These included 1. Young Men, 2. Dual protection (from a gender perspective) 3. Violence, and 4. Other themes. The goal was to attempt to articulate the subcommittee's priority themes.

2. Survey Response

The responses to the survey indicated a solid endorsement for the three themes:

1. Young Men - This topic clearly headed the list of brainstorming about Subcommittee members' interests, during the exercise carried out at the November 1999 meeting held at PAHO. Gary Barker's presentation at the February 2000 meeting confirmed our choice.
2. Condom Use/Dual Protection/Gender Analysis of Barriers to Condom Use/The Feminization of the HIV/AIDS Epidemic. This is one of the major health issues of our time. We have broadened the dual protection issue to reflect the core values of the subcommittee. Jeff Spieler argued persuasively at the February meeting that dual protection is an area that desperately needs advocacy on the part of groups like the Men and Reproductive Health committee. His strong interest in the topic, and his upcoming role as USAID steering committee member (eventually replacing Karin Ringheim) has led to the recommendation from USAID that this topic be included among our priorities for the next stage of our work.
3. Violence - It is proposed as a priority theme because the PHN Office of USAID now collects survey data that demonstrate that violence is a pervasive problem (See Pop Report by L. Heise et al. Dec. '99). USAID would like guidance on how to address this issue in a reproductive health Concept and feedback/guidance on whether/how to delve more deeply into the area.

There is a need to further define the priority themes and define specific activities, objectives and a plan for achieving those objectives in each of the priority themes. This work will be carried out by the two working teams, in meetings following the main Subcommittee meeting. The teams will begin to develop the objectives and plans for presentation at the next meeting.

3. Working Team Reports

A. R&E (Research & Evaluation) Working Team

Meg Greene, the coordinator of the R&E working team presented R&E's proposed upcoming activities. R&E is planning to support three case studies on innovative programs to involve men in reproductive health, in a gender equity-enhancing manner. These would include the process, what worked and what didn't and the outcomes, so that others might learn from, if not replicate, the programs. The first two case studies - Salud y Genero's work with men on such issues as domestic violence, and the Society Integrated Development of Himalayas work with adolescents, reproductive health and human rights, have been identified. The R and E team also plans to support some assistance to Salud y Genero to improve their evaluative capacity. R&E is also working on the next steps for the Men's Indicators Paper. Tim Williams, in consultation with the paper's authors, Elaine Murphy and Nancy Yinger, will develop some additional indicators addressing our three themes, as well as some more specific illustrative indicators which may be useful for those developing proposals. Bessie Lee suggested working with Nancy Yinger, Krista Stewart and Measure Evaluation on further developing the Indicators Paper. Salud y Genero has been suggested as a location for possibly field testing the indicators. R&E will also draft position statements for the Men and Reproductive Health subcommittee on the three theme areas. It is proposed to post these on the website.

B. IEC (Information, Education & Communication) Working Team

Michele Burger, a consultant hired by the IEC working committee, presented a report and her recommendations for an IEC two-year work-plan. The work-plan has two goals. First, to convince donors, including USAID and its CA's that gender sensitive male involvement is a worthwhile investment that will improve the sexual and reproductive health of women and men and the health of their children. Second, to convince sexual and reproductive health professionals that integrating gender sensitive male involvement into sexual and reproductive health agenda is a strategy that helps meet program goals and promotes gender equity. Michele's recommendations for achieving these goals included:

- Organizing a speaker's series on topics under the rubric of male involvement
- Disseminating the Orientation Guide with training on its use
- Presenting and disseminating the gender equity framework of male involvement
- Carrying out activities to raise visibility and interest in male involvement
- Reaching out to professionals working on violence, adolescents, etc.

3. Funding Allocation Process

The resource allocation strategy for new/upcoming projects and activities will be that that the working teams define objectives and make recommendations for activities in the priority theme areas. The working should submit a brief proposal for the activity, including who will do the activity, how much money is needed and a time frame for completion of the activity to present the co-chairs. The Men and Reproductive Health subcommittee co-chairs will make the funding decision and sign-off on planned activities.

4. Identifying Champions/Experts

The Men and Reproductive Health subcommittee needs to identify experts and champions in the three theme areas to invite to our meetings to help us with our work in these new areas. Bessie Lee suggested that the Men and Reproductive Health subcommittee design a strategy for inviting people or organizations to attend the meetings, such as inviting individuals or organizations to help on a specific project or activity. Jeff Spieler suggested reviewing the list of CA's in

the USAID User's Guide and targeting those CA's that are not involved in our meetings. A list of specific names and target organizations was made and those will be contacted. Please send any additional names and ideas for involvement to Sam who will send an email before our next meting asking for name, contact information, technical area and willingness to contact that person to invite to our next meeting. Bessie will work on targeting USAID PHN divisions, such as the Services Division and the HIV/AIDS Division to appoint a representative to join the IGWG.

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IGWG dissemination update

Nancy Yinger, in her new position as Director of Measure Communication at PRB, will be heading up the Dissemination Group for the Interagency Gender Working Group, IGWG. The Dissemination Group (Nancy Yinger, Jeff Jordan, Bessie Lee, Karin Ringheim and Audrey Seger) will develop a strategy for using the funds put into Measure Communication for IGWG, including disseminating the IGWG's tools and managing the website, to present to the steering committee. In the draft of the strategy document, the co-chairs from each subcommittee will be asked to provide information on their products to Audrey.

With regards to dissemination, the next task is the IGWG brochure. Nancy has a writer for the brochure and will have a first draft ready for our next steering committee meeting. A postcard was printed for Beijing+5 workshop and extras are available to hand out at other events. Also, the IGWG LOGO is ready and available electronically from PRB.

Cille Purser, who manages the IGWG Listserv, is leaving FHI. The management of the Listserv will be handled by PRB as part of our dissemination strategy. beginning the first of August. We also discussed the future of the Listserv. Should it be more interactive? Should it serve a larger purpose? Some people were concerned with expanding the role of the Listserv. It currently it serves only for IGWG announcements and basic IGWG information. Nancy will look into the different in consultation with the Dissemination Group.

The IGWG website will be part of the Measure Communication website. (www.measurecommunication.org) Right now, the website only includes the postcard and the flyer but as other products, are ready, please send them to Nancy for posting on the website. Links to other sites, such as RHO and other gender work created by our partners, as well as a paragraph on each subcommittee will be added. The Dissemination Group will discuss this and present a plan for the web-site at the next meeting.

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Plus-Delta exercise

Plus

Time Management
Content Presentations
Lunch
Three Theme Selected
Transparency
Accountability
Domestic Presenters
Jeff Spieler's Support
Sam's New Leadership
Thanks to Tim at JSI
Nice to have Audrey Seger

Delta
Name Tags
Introductions for Everyone
Fewer CA Updates—Longer
New persons focus areas

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Next meeting

The next USAID Men and Reproductive Health Subcommittee meeting is scheduled for August 9, 2000 at Johns Hopkins SAIS Rome building, Room 535 1619 Mass Ave. NW. Wash. D.C.(just 2 blocks from Dupont Circle Metro) from 9:00 am to 5:00 pm.

IGWG Men and Reproductive Health Subcommittee

Meeting Minutes: August 9, 2000

- Attendance and logistics
- Introductions/selected updates on CA activities
- Presentation by Ann Leonard, Population Council
- Presentation and Discussion by Mary Nell Wegner and Andrew Levack, AVSC
- Josselyn Neukom, PSI, "Addressing Gender Differentials through Condom Social Marketing Programs Targeting Adolescents."
- Discussion of the Subcommittee's role in condoms/dual protection/gender
- Reports from working teams
- Strategic planning on our thematic areas
- Emerging issues from the June IGWG Steering Committee Meeting
- Orientation guide
- Working team meetings
- Next meeting/Plus-Delta exercise
- For more information

Attendance and logistics

The meeting took place at SAIS, courtesy of JHU/CCP. Attending and introducing themselves were: Errol Alexis (Sanger), Cindy Aragon (PSI),Lucy Atkin (Sanger), Caroline Blair (AED), Michele Burger (consultant), Pax Castillo-Ruiz (IDB), Seema Chavhan (USAID), Lisa Childs (USAID)Sam Clark (PATH), Sylvie Cohen (UNFPA), Ross Danielson (consultant), Martine de Schutter (PAHO), Paul Feldblum (FHI), Bill Finger (FHI), Jill Gay (consultant), Meg Greene (CHANGE), Judith Helzner (IPPF-WHR), Ruth Hope (NGO Networks), Jodi Jacobson (CHANGE), Mihira Karra (USAID), Kurusa Kiragu (JHU/PCS), Ann Leonard (Pop Council), Andrew Levack (AVSC), Ya-Shin Lin (URC), Purnima Mane (Pop Council), Peg Marshall (CEDPA), Josselyn Neukom (PSI), Emma Ottelenghi (Frontiers), Julie Pulerwitz (Horizons), Karin Ringheim (USAID), Myrna Seidman (Georgetown/IRH), Audrey Seger (USAID), Carole

Sienche (JUU/CCP), Freya Sonenstein (Urban Institute), Jeff Spieler (USAID), Lindsay Stewart (FOCUS), Mary Nell Wegner (AVSC), Ellen Weiss (ICRW/Horizons), Amy Weissman (Save the Children), Alfred Yassa (JHU/CCP).

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Introductions/selected updates on CA activities

Sam Clark, subcommittee co-chair, noted there were a large number of newcomers and welcomed them all. He then called on people to make several brief announcements:

- Karin Ringheim, who was the guiding force behind creating the subcommittee, announced she was leaving USAID after seven years and going to PATH. She expressed her heartfelt gratitude and appreciation to all those who have made the Subcommittee a success.
- Martin de Schutter announced she was leaving PAHO and moving back to her home in The Netherlands. She also circulated a document on domestic violence.
- Bill Finger, a co-chair for the first two years, is leaving the Subcommittee, to be replaced by Paul Feldblum of FHI, a world expert on condoms.
- Ross Danielson described briefly his new role in working with the Population Council on couples communication research.
- Jill Gay described the excellent reception that USAID gave the RFA/RFP guide on involving gender, which she recently presented. She and others have developed the guide through the Interagency Gender Working Group.
- Judith Helzner circulated two book reviews on adolescent boys and gender and discussed how to send the new WHO literature review on adolescent boys to everyone.
- Sam Clark distributed a summary of four sections of papers on men/reproductive health related issues to be presented at the APHA meeting in Boston this fall. He closed the announcements by distributing the "blue sheet," which provides background on the Subcommittee for newcomers.

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Presentation by Ann Leonard, Population Council

Ann described a new project at the Population Council being coordinated by her and Ann Blanc (formerly with DHS) on "Power in Sexual Relationships." The project involves preparation for an international conference, probably to be held in Washington in 2001. Ann presented the idea that the Men/Reproductive Health Subcommittee might have an interest in this project, specifically in recommending people to participate and present and in developing the program. This first meeting might lead to regional meetings eventually. Also, Ann announced the completion of two Population Council publications on men from Nepal and Kenya and will mail them to everyone on the subcommittee list.

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Presentation and discussion by Mary Nell Wegner and Andrew Levack, AVSC

"Introduction of the Men and Reproductive Health Curriculum"
NGO partner organizations requested that AVSC develop a broad curriculum to train providers concerning men's reproductive health with a gender perspective. AVSC developed six different modules for trainer manual and a participant's book. AVSC convened experts in CBD, clinical providers, and training methodology, with reviewers from Asia, Africa and Latin America. One module introduced participants to attitudinal and organizational issues affecting delivery of men's reproductive health services and provided basic information on male reproductive health to all staff in a facility, with the objectives of exploring the benefits of providing reproductive health services to men; the importance of

considering gender issues; identifying common reproductive health problems in men; examining the role of sexuality in reproductive health and provider attitudes, and identifying barriers for providing men's reproductive health services, among others. Much information on women's reproductive health was included also. In Section One, the first module reviewed the importance of involving men in reproductive health; the range of men's reproductive health services and addressing staff concerns about working with male clients. For example, what can staff do with an angry male client? Some of the activities in the second module include addressing common client concerns, such as "will I run out of sperm?" Activities in Module 3 include discussions of gender roles and identity; sexual arousal; sexual behaviors, etc. Module 4 covers how men can support women's contraceptive choices, male contraceptive methods, etc. Module 5 covers STIs, including the physical and gender differences between men and women concerning STIs, such as power imbalances. Module 6 covers management and cost issues. Andrew Levack then led the group in a sample training activity concerning cost considerations, asking people to group various activities under no cost, medium cost and high cost.

The curriculum has been field tested in Ghana in 1999 and in the United States in June 2000; future field tests will be conducted during 2000 in the United States, Uganda, Tanzania, Nepal, and Colombia. In the United States, good results were achieved with the training – knowledge was increased, and gender-sensitive attitudes increased. Participants generally gave high marks to the curriculum. Future evaluation plans will measure changes in provider attitudes toward gender equity and numbers of men served in a facility, among others. Participants from IGWG also praised the curriculum developed by AVSC.

Andrew Levack will be moving to Thailand, where he will continue to work for AVSC.

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Josselyn Neukom, PSI, "Addressing Gender Differentials through Condom Social Marketing Programs Targeting Adolescents."

PRB's evaluation of SMASH suggested that more attention is needed for gender considerations. Good marketing needs to take into account gender issues. Funded by the Gates foundation, PSI developed a methodology to incorporate gender differentials into marketing strategies for condom promotion in Rwanda, Cameroon, and Madagascar. Goals for Rwanda included postponing the age at first sexual intercourse. PSI developed a behavior change framework for HIV/AIDS prevention, which incorporated the following concerns, such as: Do they know about AIDS? Do they believe they can die from AIDS? Do they worry about the loss of sexual pleasure? Can they negotiate condom use? Research was conducted among females and males 15–19 and males 20–24 in urban areas through focus groups, evaluations, qualitative studies, DHS analysis, etc. Research identified barriers to changes, such as concerns with pregnancy rather than HIV, sexual pleasure, etc. In step 2, PSI prioritized issues, such as girls lack of confidence in negotiating condoms use, concern with loss of sexual pleasure, lack of support from peers, etc. In Step 3, PSI designed a strategy based on the priorities. Different messages were developed for men and women. One message was of a girl saying: "Ask me to use a condom – you'd be surprised at my reaction." Or a girl saying: "It's my problem too." Another ad has: "I have a past – you have a past – we want a future."

Comments by participants included the need to develop a different model not confined by BCC, but to consider the socioeconomic framework, as well as the impact and importance of gender-based violence. Jodi Jacobson noted that another barrier is the social norms and gender stereotypes voiced by providers and adults. Jeff Speiler noted that social marketing has had some success with social marketing by celebrities on condom use. In Zimbabwe, condom use has increased, but has had no impact on the incidence of HIV. Girls should be asked about whether they can have sexual pleasure with a condom, not just men. Mary Nell Wegner asked how to market changes in gender attitudes to donors, as this is not quickly achieved.

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Discussion of the Subcommittee's role in condoms/dual protection/gender

Following Josselyn Neukom's presentation on how gender-based research was influencing the development of social marketing programs, the Subcommittee was scheduled to move into a discussion of one of the Subcommittee's priority areas: condoms/dual protection/gender issues. Because of time pressures and the type of presentation and questions that followed, however, the discussion that followed focused more on the PSI project itself rather than on next steps for the Subcommittee. Several persons including Jodi Jacobson of CHANGE and Sylvie Cohen of UNFPA commented that while PSI was making a great effort to incorporate gender-based research into its projects, gender and behavior change could be seen from a broader view than the factors in the model presented. Neukom replied that the model presented could be adapted to other issues besides simply condom use, such as STI treatment or other goals. Nevertheless, it seemed challenging to incorporate long-term goals of changes in gender norms into more short-term goals of increased condom use or STI treatment.

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Reports from working teams

a. **IEC.** Mary Nell Wegner, who chairs this working team, gave a brief report. She encouraged some of the new people to join this group; introduced Michelle Burger, who is working with this working team as a consultant; and summarized briefly the workplan as now envisioned by the working team, which is to be fleshed out at the meeting later in the day. The first project of the working team is to plan dissemination of the orientation guide, funded in the first round of products, and to continue to help disseminating the other original products. For example, the HIM CD-ROM is out of print and needs to be reprinted. This working team will work with dissemination through the overall Gender Working Group dissemination process, coordinated by PRB. It is now in the process of developing a plan for specific projects around the three Subcommittee priority themes.
b. **Research and Evaluation**. Meg Greene, who chairs this working team, reported that three case studies are underway. They will focus on Salud y Genero in Mexico, Society for the Integration of the Himalayas in India, and Stepping Stones in Uganda. The working plan is to produce these separately as well as together with a synthesis, bibliography and list of resources. The team is also developing position statements for the website on our three areas of interest. Jeff Spieler is drafting one on dual protection from a gender perspective; Meg Greene and Diane Rubino are working on a violence statement; and Amy Weissman and Jill Gay are working on adolescent socialization. Tim Williams and Meg Greene are working on developing more specific measures in the areas of special interest to our subcommittee, building on the indicators product.
c. **Budget update**. Karin Ringheim of USAID summarized the current budget. The Subcommittee currently has $357,000 with $86,000 of that committed to programs, leaving about $270,000 to be programmed. Jeff Spieler pointed out that we needed to leverage these funds where larger amounts are available and also noted that we need to get these committed to worthwhile projects if we want to secure funds in the next fiscal year.

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Strategic planning on our thematic areas

The idea is for all Gender Working Groups to be more rigorous and systematic about their work, and to coordinate their efforts to influence the work of USAID and other colleagues in the reproductive health field. The IGWG Steering Committee is trying to take a more active role in this coordination, and had requested that each sub-committee put together a matrix of its activities, timing, resources, etc. (Bill Finger noted that just choosing the priorities and getting to this matrix represented a huge amount of work and congratulated us all on this iteration!) Audrey Seger has now drawn all of these together to give an overview of the IGWG's work, and she noted that the IGWG as a whole is willing to offer help in moving our work forward. Judith Helzner noted that although the Steering Committee is trying to coordinate the work of various sub-committees, the heart of our work is being done by the working teams.

Toward the end of this discussion, the co-chairs asked us to discuss the matrix of activities in our working team groups. For each of the three thematic areas of our work, there are similar categories of objectives. Input on missing items such as the timing, implementing agency, target audience, or funding should be given directly to the working teams, e.g., adding objectives to some of the activities. Jeff Spieler suggested we consider the "no cost" idea of getting organizations to see how our agenda fits into theirs and encouraging them to take our ideas over. He also suggested reinventing the boundaries of the working teams, asking us to think about what would work best for us.

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Emerging issues from the June IGWG Steering Committee Meeting

- Dissemination plan: A small group is developing a strategic plan for disseminating the products of the IGWG. The money for the Men and Reproductive Health group is parked in several locations, including at Measure Communication (PRB). We will soon want PRB to help us put together a work plan for disseminating the products of the Men & Reproductive Health group as well as for the IGWG as a whole.
- ACVFA: The American Committee on Voluntary Foreign Aid produced an assessment of the Gender Plan of Action (Brian Atwood, 1996). The IGWG has been invited to review that document and to present the assessment to ACVFA later next week, after the steering committee. Bessie Lee of USAID noted that the PHN came out relatively favorably in the report, thanks in part to the IGWG's work. PHN is now working with Democracy and Governance and with the WID office to develop a stronger consensus document in responding to the report.
- Audrey Seger gave us an introduction to the new logo and coherent mission statement of the IGWG. Concern that the overall group's products were not consistent nor recognized as products of the same entity led to the development of a new logo and attempts to coordinate the efforts of the sub-committees. The dissemination group is now working on turning a one-page description into a brochure.
- The transition of the listserv from FHI to PRB has not been completely smooth, but those who had been subscribed and haven't succeeded in doing it again will be hearing from PRB.

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Orientation guide

Judith Helzner introduced the guide, noting how exciting it was to see the guide approaching completion after a long process of development. Bill Finger, who presented the orientation guide, recalled that the field test had been presented to the group a year and a half ago, and that the team had been challenged by the range of ideas and the varied audiences to which they wanted to present the ideas. They concluded that interactive exercises would not work for this presentation for CAs, and developed a generic text that can be adapted depending on the audience. The IEC working team is going to think about how the orientation guide can best be used. The advantage is that as a slide show with text modules, the orientation guide can be repackaged in many ways.

There are approximately 100 slides, that could be zipped through in a brief training or presented in smaller chunks. The guide addresses critical reproductive health issues in five segments: family planing, STIs/HIV/AIDS, adolescents, safe motherhood/family wellbeing, and violence. Bill Finger presented the STI segment, and spoke about masculinity as a risk factor. Of particular interest was the condom discussion, covering negative gender stereotypes and how these should be avoided with the single goal of just pushing condoms for family planning purposes. The text states that there is a need to support men's positive actions and to support gender equity. Starting in September, the Orientation Guide will be available for presentation at USAID and CAs, and more broadly available a couple of months after that. Interested people should speak to Mary Nell Wegner.

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Working team meetings

There was a useful discussion of how our sub-committee's meetings are organized and whether the working teams should be re-divided along different dimensions. The decline in interest and attendance after lunch led some to suggest having our working team meetings first, *then* have cross-cutting discussions. The general sentiment was also that we need to have more discussion after the presentations and about the activities of the working teams. Emma Ottolenghi suggested trying out a re-ordering and then voting after one round of organizing the meeting that way.

There is considerable overlap between the working teams and a couple of people said they would benefit from clarification as to what the responsibilities of each are. Ann Leonard explained that the agendas of the current working teams were haphazard as the result of the collapse of the four original teams. Even so, it is often hard to drum up sufficient participation in the working teams, although the R&E group has been fortunate that way. One of the assignments for the working teams was therefore to describe what they see as their areas of focus/endeavor.

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Next meeting/Plus-Delta exercise

Our next meeting will take place at CEDPA on Tuesday of Thanksgiving week, the 21st of November.

Plus (do again next meeting)
Well-prepared presentations
Good attendance
Good cake
Nice room

Delta (to change)
Dual protection next steps
Change caterer
More time for workplans
Put working group meetings in AM; try different meeting formats.

IGWG Men and Reproductive Health Subcommittee

Meeting Minutes: November 21, 2000

- Attendance and logistics
- Working team meetings
- Working teams report/work-plan discussion
- Presentations
- Further discussion
- Updates on selected CA activities
- IGWG steering committee report/other business
- Next meeting/plus-delta exercise
- For more information

Attendance and logistics

The meeting room was kindly provided by CEDPA at their offices. Attending and introducing themselves were: Michal Avni (USAID), Gary Barker (Promundo/JSI), Lissette C. Bernal (AVSC International), Michele Burger (consultant), Seema Chauhan (USAID), Sam Clark (PATH), Nick Danforth (Consultant/Brandeis), Paul Feldblum (FHI), Jill Gay (consultant), Meg Greene (Population Action International), Jay Gribble (IRH/Georgetown), Alessandra Guedes (IPPF/WHR), Judith Helzner (IPPF-WHR), Jodi Jacobson (CHANGE), Mihira Karra (USAID), Tabitha Keener (USAID), Jennifer Knox (JHU/CCP), Peg Marshall (CEDPA), Elaine Murphy (PATH), Emma Ottolenghi (Frontiers), Julie Pulerwitz (Horizons), Karin Ringheim (PATH), Audrey Seger (USAID), Jeff Spieler (USAID), Kellie Stewart (USAID), Ellen Weiss (ICRW/Horizons), Amy Weissman (Save the Children).

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Working team meetings

For the first time during these meetings, time was set aside for the working teams on Research and Evaluation and on Communication to meet in the morning for 90 minutes and report back to the larger committee. The main task for these meetings was to complete and correct the annual workplan.

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Working teams report/work-plan discussion

Report Back from Research and Evaluation Working Team

The Research and Evaluation working team included Meg Greene, Chair, Gary Barker, Jeff Spieler, Jay Gribble, Tabitha Keener, Paul Feldblum, Julie Pulerwitz, Sam Clark, Amy Wiesman, Jill Gay, Emma Ottelenghi, Ellen Weiss, Peg Marshall and Karin Ringheim. Meg Greene reported. Members of the working team have drafted statements on our 3 priority topics: Jeff Spieler—dual protection; Amy Weissman and Jill Gay—adolescents and Diane Rubino and Meg Greene—gender-based violence. The plan is to circulate these within the working team (or full membership too?) for review and comment. When complete, they will be included on the Measure Gender Working Group website, used in advocacy, etc. The statements will reflect the specific gender interests of the Men and RH subcommittee in these priority themes.

The working plan includes an item to meet with experts in the field. The team felt that this is a two way street. In addition to inviting experts to present at our quarterly meetings, the Men and RH subcommittee should be represented at meetings that are of importance to our work, and where we can make presentations, provide input into action plans, etc. The team proposed that funds be allocated toward sending representatives to selected meetings, including international meetings. For example, a conference on dual protection is being planned for West Africa and it would be worthwhile to have a representative at this meeting.

The working team has commissioned a case study on each of our three priority themes. The case study on working with adolescents, particularly men, is being written by Barbara Crook, formerly of PATH Seattle, in collaboration with the Society for the Integrated Development of the Himalayas. A draft should be ready for review in January. A case study on working with men to reduce gender-based violence is being written by Benno de Keijzer of Salud y Genero in Mexico. A draft will be completed by March. The third case study on condom promotion, dual protection and safe sexual practices will describe the work of the Stepping Stones project and will be written by Gill Gordon and Alice Wellbourn, who developed the curriculum. It is anticipated that by late spring, the three case studies will be completed. A review committee of R and E team members will be assigned to each of the three case studies, and will include USAID staff. (Ellen Weiss and Julie Pulerwitz expressed interest in reviewing the Stepping-Stones case study, and Julie also expressed interest to review the Salud case study.) Those interested in reviewing a specific case study should contact Meg Greene.

The Men and Reproductive Health subcommittee is also supporting the development of one of 4 workbooks for health workers and providers on working effectively with adolescent boys. These are being produced through a collaboration between IPPF/WHR and 4 NGOs, 3 in Brazil and Salud y Genero in Mexico. The initiative is being coordinated by Insituto PROMUNDO in Brazil. Each NGO is producing one of the 4 workbooks. The topics are sexual and reproductive health, fatherhood, violence, and mental health including substance abuse and suicide. The subcommittee is funding Salud y Genero to produce the latter workbook on mental health. All 4 workbooks have been drafted and are being reviewed. They are each about 75 pages and will be produced in Spanish and Portuguese and field-tested in Bolivia, Mexico, Peru, Colombia and Brazil. Gary Barker suggested that the Committee might wish to support their translation into English, for use in other parts of the world. This would be relatively inexpensive, around $10,000. It may be worthwhile to also adapt the exclusively Latin American data and examples to include some data from each region. This would increase the price of translation, but may make the workbooks more broadly useful. PAHO is interested in funding an evaluation of the workbooks. The subcommittee could advocate for PAHO to fund a longitudinal evaluation.

The Men and Reproductive Health indicators paper written by Nancy Yinger and Elaine Murphy was recently presented at APHA by Elaine and is on the PATH RHO/M&RH website (go to http://www.rho.org/html/menrh.htm ; Also it is to be published by PRB Spring 2001. Contact nyinger@prb.org . The R and E team plans to further this work by developing specific indicators on our three priority topics. Meg Greene and Tim Williams will work on developing an annex to the indicators paper.

The team discussed what our committee could do to better understand and address constraints to condom use from a gender perspective. The role of our subcommittee is not to get men to use condoms per se (which is the work of may collaborating agencies [CAs]), but to help CAs better understand the gender issues and dynamics that affect negotiating/ using condoms. USAID, FHI, the Population Council and others are planning a workshop for CAs on dual protection for February 21st . It was recommended that one or more presentations include information on gender aspects of dual protection. We could be helpful in articulating how a concern with gender is translated into programs. Meg volunteered to work with Jeff on revising Ellen Weiss, Jodi Jacobson and his presentation on dual protection to include a stronger gender component. A comparative advantage for our committee would be to focus on using condoms with the primary partner, e.g., caring about and protecting one's wife or primary partner.

We discussed positive deviance approaches to addressing all three priority themes individually, as well as the intersection between adolescent boys, violence, and dual protection. The committee could potentially play a role in funding research and evaluating programs. The subcommittee could set funds aside to respond opportunistically to identify positive deviants within a particular study so as to include them in follow-up sub-studies. The subcommittee could also entertain specific proposals if such studies were not or could not be done within existing CA contracts. The subcommittee could also serve as an advocate to encourage foundations to fund more work, for example on violence. The orientation guide will be useful for this kind of advocacy work.

The work plan presently includes a literature review but the team concluded that literature reviews on all three themes were currently being done or were recently completed. These include the Horizons/Frontier review of condom use and dual protection, which should be completed by February, the review of adolescent programs done by Shanti Conly, Lori Heise's Pop Reports on violence, which has an extensive literature review, Peter Aggleton's review of a gendered approach for UNAIDS, and the update of Cynthia Green's review of male involvement for UNFPA recently done by Michele Burger. The Men and Reproductive Health section within the PATH Reproductive Health Outlook website includes an update of the literature every 6 months. The workplan should be revised to state that the team will keep abreast of the literature.

Report Back from CommunicationWorking Team

Michele Burger reported on the Communications subcommittee, which included Michele Burger, Kellie Stewart, Mihira Karra, Audrey Seger, Jodi Jacobson, Lisette Bernal, Jennifer Knox, and Elaine Murphy. In Mary Nell Wegner's absence, Michele and Audrey ran the team meeting. The Working Team spent almost an hour reviewing the workplan in detail. The committee is organizing the orientation guide training of trainers for December 1st. Joe Coyle, a consultant affiliated with the Population Leadership Program at USAID, will facilitate the training for about 15 people. A letter is being sent to about 30 organizations requesting an opportunity to present the material. The team anticipates that about 10 presentations will be made to CAs and donors by teams of trainers in the spring of 2001 and then the orientation guide will be distributed more broadly for use by CAs, Missions, etc. The working team will be responsible for developing the dissemination plan. There are already many requests to use the material. Michele Burger is the contact person and coordinator for scheduling sessions. Plans are to schedule several presentations in the next six months.

A speaker series on the three priority themes is being developed. The matrix that Jennifer Knox created, listing potential speakers, their affiliation, skills and person making the recommendation was presented. The list of speakers will be revised based on the following criteria: international expertise specific to the PHN sector, gender sensitive, experienced in both clinical and non-clinical settings. The primary target audience is USAID. An updated list of speakers will be circulated to the full Subcommittee with a cover note listing the criteria and asking members to either eliminate speakers

who do not meet the criteria, or provide the area of expertise, affiliation, and contact information of the speakers they recommend.

The Communications team will play a leading role in disseminating the case studies and PRB will be asked to assist in disseminating the workbooks. The Communications working team also discussed the forthcoming dual protection workshop and will work with Mihira and Jeff to identify a plenary speaker who can address gender issues.

The CD-rom is being reissued. Contact has been made with those individuals who granted copyrights to request permission for an additional 1000 copies. A suggestion was made that we raise this figure.

We further discussed how the IGWG as a whole can have greater visibility at international meetings and reproductive health conferences that are likely to cover one or more of our three themes. For example, there is a forthcoming Asia Pacific meeting on Reproductive Health in the Philippines. [An abstract on the subcommittee's work was later submitted for that meeting.] Suggestions can be put forth at any time to one of the co-chairs about other meetings to which we might contribute. Sam Clark hopes to organize a panel for the spring meeting of the Psychosocial Workshop prior to PAA.

The Team agreed that promoting adoption of indicators for assessing adolescent male (AM) programs would require several steps such as disseminating the indicators, using a similar strategy as for the Orientation Guide (sending out speakers to meet with CAs to encourage them to adopt these indicators) and the active involvement of USAID.

The Working Team also agreed to work on increasing awareness among key audiences about AM services. A possible strategy is to support the participation of a resource person from the Subcommittee, knowledgeable about AMSRH, at meetings such as the upcoming conference in the Philippines. A meeting to be hosted by the Society for the Advancement of Reproductive Care (SARC) were also mentioned. Another suggestion was to support the dissemination, and if necessary the translation, of PAHO's recent multi-country qualitative research on young men.

The Team agreed it could play a role by adding a gender aspect to dual protection. Gary Barker has a proposal that he is submitting to the Research and Evaluation Working Team for supporting work on gender violence. The Population Council submitted a proposal requesting $15,000 for its meeting on Power and Sexual Relations to be held in Washington, DC March 1–2, 2001. On December 11, the Population Council is hosting a planning meeting.

A proposal was presented to hire Michele Burger for 8 days to update the RHO website.

Members agreed that links should be added to the site and that abstracts cited should be linked to papers in their entirety. Consideration should also be given to including a chart listing the various organizations working with men in reproductive health.

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Presentations

Alessandra Guedes, IPPF/WHR. "Integrated screening and services for gender- based violence within sexual and reproductive health programs in Latin America."

Following the introduction of a conceptual model of gender violence adapted from Population Reports but adding a component about men by Judith Helzner, Alessandra Guedes from IPPF/WHR made a presentation titled "Integrating screening and services for gender-based violence within sexual and reproductive health programs in Latin America." Her presentation described the results of a 3-country project to integrate gender-based violence (GBV) into IPPF clinical

programs in the Dominican Republic, Peru and Venezuela. For further information on this project, please check out IPPF/WHR's website at www.ippfwhr.org .

Guedes set the stage by showing ways in which GBV is linked to reproductive health and adverse outcomes for women. Survey information from Latin America indicates that GBV is common there, and that many men find violent acts to be acceptable in various contexts. IPPF/WHR, with funding from the European Commission and the Gates Foundation, initiated the project in 1999. The objectives are to strengthen institutional capacity to offer services to victims of GBV; to increase awareness of GBV as a public health problem; to improve legal protection to survivors of GBV; and to increase knowledge about interventions that sexual and reproductive health services can undertake.

Baseline KAP of service providers revealed that the majority has recently questioned clients about GBV, but a substantial minority harbor attitudes that blame the victims for the abuse. A screening tool increased the ascertainment of victims of GBV markedly at the Venezuelan site. The tool has been applied at all three sites, with the Dominican clinics reporting the highest prevalence of GBV (over 30% of new clients report emotional, physical, sexual or childhood sexual abuse) and Peruvian the lowest prevalence (7% of new clients). It is important to note, however, that these differences are likely to reflect the varying levels of implementation of screening at the different locations rather than actual differences in the prevalence of GBV among client populations. This will continue to be monitor closely as screening and services are fully integrated in the different countries.

This work in GBV suggests several dilemmas. The behaviors need to be addressed among men and male adolescents, but reproductive health services aimed primarily at women may not be well-placed to work with perpetrators, although they would be well-placed to undertake activities in the area of violence prevention through IEC and/or advocacy. Resources are scarce, and how to divide them between victims and perpetrators is not clear. And interventions to prevent GBV, while urgent, are of unknown effectiveness.

Presentation by Gary Barker, Instituto Promundo. "Men & gender-based violence: from aggressors to partners in prevention"

Gary Barker presented on the roots of men's violence against women, and implications for preventing men's violence against women. He drew on examples from his research in Brazil to highlight how this violence can be prevented, and how men could be included as "partners in prevention." Only some of the main points as well as issues not raised in the slides are presented in the notes below.

Gary proposed that men's violence stems from 3 factors:

1. Socialization—how men are raised and expected to act. (e.g., Men's sense of entitlement toward women – that men expect sex under certain circumstances, and believe it appropriate to react with violence when refused sex.)
2. Situational Factors—current relationship and other factors. (e.g., Stress and disempowerment caused by employment, and men's reaction to this stress leading to violence expressed toward a partner, to regain power in another domain.)
3. Individual Factors—individual variation. (e.g., Inability to control anger).

Gary spoke of the importance of the social context, particularly at a very young age, where parental and other models influence future attitudes and actions regarding violence. Gary pointed to evidence that shows that non-sexual violence in the home is most often directed at boys, and that boys who have been victims of violence need access to services, and are more likely themselves to use violence in their intimate relationships.

Learning from Non-Violent Men: Gary's dissertation research explored positive deviance among young boys—where the characteristics of young boys who manage to counter the dominant (or at least common) social norms around violence are explored. He found that young boys who refused to engage in violence often had witnessed violence, but then had

witnessed a negative reaction within the family to the violence, or had somehow seen the "cost" of the violence within the family.

Gary noted that role-play exercises used in many programs often demonstrate negative relationships and difficult situations, but that they could and should act out positive, supportive and non-violent relationships as well. It is important to note that women often indicate that they do not want to leave violent spouse or partner—they just want the violence to stop. Gary pointed out the importance of strategic alliances—that the relationship between Instituto PROMUNDO and women's rights groups, and the judicial system (i.e., for referral of perpetrators of violence) have been fruitful and very important for the success of the programs. Gary concluded by asserting a need for more research on a large scale. In particular, while some research has been done in the developed world, it remains unclear what factors may lead to violence in developing countries. There is a lack of quantitative and qualitative research on men's attitudes and use of violence in intimate relationships in developing countries. There are data from a number of countries on women's victimization by domestic violence, but little research on men that would permit identification of correlates of such violence, and offer insights for prevention.

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Further Discussion

What is the appropriate role for the subcommittees in addressing men and gender-based violence?

Following up the presentations by Guedes and Barker, we had a lengthy and wide-ranging discussion about the difficulties their projects had faced, and problems faced in using an overburdened, underfunded, and untrained reproductive health system to deal with GBV.

Most thought that screening for GBV should implemented because it is at least important for women to know they are not alone in being victims of violence, that they do not deserve to be battered or raped, and that there may be some local remedies available even if a formal referral system is not yet in place. For example, interventions might be feasible by extended family or community members. Increasing awareness among all women also helps pressure leaders to improve referral systems. Before systems improve, all must be made aware a problem exists. All too often GBV is not recognized as significant.

At least one participant felt it was not realistic for this subcommittee, which does not have a clear role in making policy concerning reproductive health training, to recommend new approaches to training reproductive health counselors. This cadre of service providers are usually already seriously undertrained and overworked, and cannot be expected to add GBV as well as sexual health counseling to their duties—in addition to reaching out to counsel men, often for the first time. The time, skills, funds, and commitment are simply not available.

Other meeting participants were more optimistic, generally agreeing that health care providers need to have at least rudimentary training in detecting and preventing GBV. There are several good models for provider training, including the two discussed above. The biggest problem in training and intervening is how to deal with GBV without further angering the abuser; women are often reluctant to report abusive husbands either because they risk more violence, or because they do not want to lose the spouse on whom they depend. In some cases in Asia, women in immigrant families have been told that abusive husbands can be deported, but those women have usually been unwilling to report husbands in fear of losing their support.

In addition to lacking time and skills, providers will have a hard time knowing what to do. Simply expelling the abusive partner from the home is a complex and difficult remedy, and there can be complications or even retribution for both the providers and the partners. Usually it is necessary for the woman involved to make the decision about how to proceed, and in most cases her opinion must be respected, but extended family, community members, and customary law may be

important factors too.

Providers should remember that unless women are screened in private, they may not be able to disclose their experience with violence. At the same time, some victims of violence (in particular victims of sexual violence) indicate that they feel more comfortable undergoing gynecological examination, if they are allowed to have a partner or friend with them. Therefore, the ideal protocol should call for an intake procedure with the woman alone, at which time the health care provider can ask the client whether she would like to have her partner or friend join the consultation.

As in all programs designs, the importance of counseling and referral for GBV depends on local situations and concerns (for example, see the IPPF/WHR BASTA newsletter, pp. 8–9. For a copy please check out IPPF/WHR's website at www.ippfwhr.org . Programs must also look beyond clinic walls, especially when reaching out to counsel men—who tend to be less likely than women to visit clinics in the first place—by communicating with men at schools, sports, in the military, the workplace, etc. Schools are important both for general education, and for GBV prevention education. A study in India showed that both boy's and girl's education levels affected the prevalence of GBV, regardless of educational content. Schools also can address general conflict resolution and communication skills not directly related to gender, helping youth understand the importance of careful communication (how to articulate, not gesticulate).

Mass media can play a key role. PCS has tested effective soap operas with men changing diapers, respecting their daughters, and opposing GBV.

GBV prevention programs are under way in many countries, and those new to this issue should be careful not to reinvent the wheel. These interventions were the main focus of an annual meeting of the NCIH, now Global Health Council, and a workshop held at the Population Council, and many recent publication by Lori Heise and others.

In some places the case for preventing GBV is already known; the challenge is to scale up smaller pilot programs to become full-fledged, continuing activities. Just as increasing numbers of family planning providers are being trained to counsel on issues of sexuality and sexual health, so are more of them recognizing and affecting GBV, linking work in different social and government agencies to produce coordination and synergy.

The following are some of the summary points for this discussion made on a flip chart. These points are not in order of priority and additional discussions are needed to determine the most appropriate investments on men and violence for RH providers.

- Provider training is needed
- Identify key messages for client
- Policies/guidelines regarding females' permission to invite males into consultation.
- Create enabling environment/address community norms (not just clinic)
- Engage men to address GBV & men's organizations
- Social informational campaigns, behavior change/awareness raising
- Collaboration with girls' and boys' education sector/programs
- Develop links with community-based approaches (links w/CBD's?).
- Expand our knowledge re: regional issues in GBV and continue to educate ourselves from past work/conferences
- Advocate for funding to programs addressing GBV
- Provide seed funding and networking with men's groups
- Education and advocacy within USAID
- Advocate for specific activities among specific CAs; bring them together to share information.
- Identify these programs (including small, little-known programs with men)
- Help with capacity, evaluation, going-to-scale
- Develop a survey instrument for men on GBV

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Updates on selected CA activities

Incorporating Gender into RFAs: Jill Gay presented examples of how the new RFA integrates gender. PRB will publish the RFA next month. It will be mailed to missions with a cover letter explaining its development and advertising the HIM CD-ROM.

Population Council Meeting on Power in Sexual Relationships: Ann Leonard informed members that the Population Council will be hosting a meeting on Power and Sexual Relations March 1–2, 2001 in Washington, DC They will invite about 100 people and are looking for a venue in D.C. that will not use a lot of resources. A planning meeting will be held December 11. Input from members is welcome in terms of agenda items and possible presenters.

HORIZONS Gender and Sexual Relations Research Tools: Julie Pulerwitz distributed copies of a web page HORIZONS developed as a research tool for data collection instruments and methods related to gender and sexual relationships. Julie asked for input from members. The page will be posted in the near future.

JHU/CCP: HIM CD-ROM: Jennifer Knox reported that JHU/CCP is in the process of collecting permission to produce additional copies of the HIM CD-ROM. To date they have received 50% approval. There are currently 291 requests for the CD-ROM and they receive about 10 requests per week. Plans are to get approval to reproduce an unlimited number of CDs in order to avoid having to seek permission every time it needs to be re-issued.

Overview of APHA Task force on Men and Reproductive Health: Sam Clark gave a brief overview of the APHA meeting and informed members that abstracts on papers related to Men and Reproductive Health are available on the APHA website: www.APHA.org/meetings/ . He mentioned there were interesting sessions on dual protection including papers that present detailed gender analysis on condom use. Sam congratulated Judith Helzner and Meg Greene on becoming elected to the APHA Population, Family Planning and RH Section leadership positions. Some thought was given to how APHA and the Subcommittee could collaborate. For the time being, both organizations agreed to cross-reference each other as much as possible.

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IGWG steering committee report/other business

Update on Steering Committee Meeting

Audrey Seger reported on the last Steering Committee Meeting. Scott Radloff is now serving as Senior Advisor to the Gender Working Group and Mary Knox as the Permanent Representative of the WID office. Judith Helzner and Sam Clark presented the two modules of the Orientation Guide. The initiative to train trainers came out of that presentation.

The IGWG website maintained by PRB is being updated. A mailing was sent out through the listserv asking for suggestions for making the website more useful. The Gender Guide is being coordinated with the MAQ exchange since there is an overlap with the Quality of Care. The GAP Subcommittee is receiving training from CEDPA on gender training.

One of the major issues discussed by the Steering Committee is the next step for the Gender Working Group. Topics discussed included membership, need for support and front office endorsement; need for a plenary session to assess if objectives were met and to develop new ones. The plenary session is scheduled for March 22, 2001. All Subcommittee

members are invited. There will be an effort to cast a wider net to attract individuals from CAs that are not currently participating. Audrey requested that Subcommittee members send her names of people to invite to the plenary session.

The agreement to carry out an operations research study in Bolivia with PROCOSI was signed and the study is moving forward.

Gender Portfolio Review

The Office of Population went through a review in which three themes were considered: PAC, MAQ, and Gender. They examined work undertaken by CAs that take gender approaches. Estelle Quain, Michal Avni and Audrey Seger made a presentation on gender to the Office of Population. The CAs highlighted in the presentation are those that participate in the Gender Working Group.

Website

Audrey asked members to submit items for the IGWG website to Brit Herstad, the manager of the site at PRB. See the website at: www.prb.org/IGWG.

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Next meeting/plus-delta exercise

Sam Clark agreed to follow up with Subcommittee members about their preference for the next meeting. [The next meeting is set for March 12, 2001.]

Plus (to do again next meeting)

- Master stroke—AM working groups—good structure
- Good amount of time for discussion of presentations
- 2 excellent presentations
- PPT worked
- J. Helzner good focus management for discussion.
- Organized
- "Blue" Background Sheet
- "in-house" access to food
- Venue—thanks CEDPA
- Food was good.
- Sam's attention to detail/preparation.
- Finishing on time!

Delta (to change)

- Lose people by the PM inevitable.
- Increase time for discussion by PPT ? working teams.
- Have examples of some of the products we have produced, especially for newcomers.
- Expand on acronyms list

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IGWG Men and Reproductive Health Subcommittee

Meeting Minutes: February 27, 2002

- Attendance and logistics
- Report of the working teams to the committee
- Update and discussion on IGWG TAG and future directions
- Update on MCSR dating violence prevention effort
- Discussion of planned IGWG dissemination activities
- Brainstorming/plans for SOTA M/RH dissemination conference
- Updates re: selected M/RH and related CA activities/other business
- Next meeting/plus-delta exercise
- For more information

Attendance and logistics

The meeting was held at the Johns Hopkins University School for Advanced International Studies (SAIS) Kenney Auditorium, from 9 am to 5 pm. Attending were: Erin Anastasi (IRH/Georgetown), Mark Austin (USAID), Michal Avni (USAID), Lucretia Brosey (The Hunger Project), Guy Chalk (JHU/PIP), Sam Clark (PATH), Jay Gribble (IRH/ Georgetown), Judith Helzner (IPPF/WHR), Victoria Jennings (IRH/Georgetown), Jeff Jordan (Futures Group International), Tabitha Keener (USAID), Steve LaVake (YouthNet—Family Health International (Deloitte and Touche)), Jim McMahan (INTRAH), Sarah Martin (JSI), Manisha Mehta (EngenderHealth), Diana Prieto (USAID), Julie Pulerwitz (Population Council), Karin Ringheim (PATH), Debbie Rogow (Population Council), Diana Santillan (JSI/EWRP), Jeff Spieler (USAID), Kathleen Taylor (PAHO), Alfred Yassa (JHU/CCP).

Victoria Jennings opened the meeting by introducing herself and Sam Clark (Co-Chairs) and asking participants to introduce themselves. Next, Sam led an explanation of the proposals endorsed and submitted to the IGWG for funding. (He referred people to the minutes of the previous meeting, which describe the process.) A total of 7 proposals were endorsed by the M/RH subcommittee, including the following:

1. Lessons Learned Forum on Men and Reproductive Health
2. Dissemination Conference for SOTA best practices regarding male involvement and gender-sensitive programming
3. Involving Men in Family Planning: Learning from the Community of B'elejeb' B'atz (Guatemala), submitted by IRH/Georgetown
4. The Role of Men in Reproductive Health and Gender- Based Violence: Practical Guidelines for Researching Men and GBV (stemming from Bellagio conference), submitted by Gary Barker, Benno de Kaizer, and colleagues
5. Conference in Rio de Janeiro to train and disseminate set of M/RH workbooks (for young men), submitted by Instituto ProMundo
6. Men and GBV in Kenya, submitted by EngenderHealth
7. Men and RH in Rural Cambodia, submitted by EngenderHealth

Sam noted that the IGWG TAG had reviewed the proposals and short-listed selected ones for funding. However, a final decision regarding funding has not yet been made.

The Lessons Learned Forum (item 1 above) was not short-listed for funding. This proposal was designed to allow for the M/RH subcommittee to continue its work in a different form. The M/RH subcommittee has lost its funding, but may participate in the global dissemination conference (item 2 above), which was short-listed for funding. (Final decision pending.) Sam suggested the initiation of an M/RH task force to be active for the next year to prepare for the dissemination conference.

Diana Prieto (IGWG Coordinator) shared her insights into the process. She offered to make available TAG comments on each proposal, and distributed comments on the Lessons Learned Forum and the global dissemination conference to the group. She informed the SC that a total of 6 proposals (of 139 received), were short-listed for funding, among them the global dissemination conference and EngenderHealth's Men and GBV project in Kenya. IGWG submitted their budget and is awaiting a decision regarding funding of the short-listed proposals.

In response to a question from Jay Gribble, Diana explained that all of the short-listed proposals came from CA's and all addressed one or more of the priority areas (Male Involvement, GBV, HIV/AIDS, and Adolescents). They also represented a variety of regions and most entailed evaluation of an intervention.

Karin Ringheim raised the issue of what would become of the planned work of the M/RH SC (orientation guide, dissemination of other SC products), who/how to carry on the work of the SC, etc. Sam Clark replied that the SC exists until June 2002, and that we knew previously that it would compete for funding with other initiatives. As next steps, he identified 2 options: 1) working to help organize the global dissemination conference and 2) extending the SC on an ad hoc basis.

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Report of the working teams to the committee

Communications Working Team

Jim McMahan, Chair of this working team reported on the team's meeting.

Orientation Guide. The OG is nearly ready for distribution. It now includes interactive activities for each module, as well as facilitator notes. Approximately 150 orders for it have been placed so far. About 3,000 CD-ROMS and hard copy

binders (for those who've already ordered) will be printed. They will be ready around the end of March. Diana Prieto requested people to send her an e-mail if they would like to comment on the OG. In addition, The SC is looking for funding to translate the guide into other languages (Spanish, French, etc.) The content of the OG will eventually be downloadable from the website and linked to IGWG's site.

Speaker Series. There is a possibility of having a speaker at the next SC meeting. Gary Barker was suggested, as he will be in town in May.

Dissemination Conference. Members were interested in continued participation as a task force, and need to divide up tasks and responsibilities. The organizing agencies (PATH, PRB, and EngenderHealth) invite others to participate in efforts to plan and organize the conference.

Research and Evaluation Working Team

Julie Pulerwitz, Chair of this team, reported on the results of the team's session.

Case Studies. The 3 case studies are near completion and will be finished by the next meeting. The Salud y Genero case study is the nearest to completion. Karin Ringheim and Diana Santillan will review it before it is passed on to PRB. The SIDH case study is in the process of being edited, which Meg Greene is currently handling. The Stepping Stones case study needs the most work. Julie is working on it and has recruited a consultant/editor to review and finalize it. A first draft will be ready by March 8. The M/RH Co-Chairs, as well as Jay Gribble and Karin Ringheim will review it.

Julie and Meg are soliciting comments to the Introduction to the case studies. Julie will send out the Intro and the Executive Summary to all team members for feedback. The goal is for each case study to be about 25 pages, plus an executive summary.

Dissemination of the case studies is to be discussed in the afternoon session with PRB.

Statement on Adolescent Boys. The statement, entitled "Adolescent Boys: Meeting Their Needs and Addressing Gender Equity" is complete, after input from Julie and Karin Ringheim, who added elements of gender equity. It is set to go up on the RHO website along with the other 2 statements soon. Suggestions were made to ensure that it also goes on the IGWG website and that the RHO and IGWG websites be linked (if they are not already).

Inventory of Organizations Involved in M/RH. Julie has taken inventory of Horizons projects, and Paul Feldblum has done the same for FHI. Julie is requesting information from others. The team discussed how best to disseminate the inventory (Hard copy? By e-mail? Internal circulation within the SC? Searchable database?) as well as how to maintain and update it. The inventory would contain information such as the name and type of project, purpose, activities, host organization, PI, funding, etc.

HIM CD-ROM. Alfred Yassa reported that the CD-ROM is currently being evaluated by its users. Results are expected in June 2002.

Safari of Life game. The game was evaluated by a total of 500 participants in 11 countries, including the United States. The evaluation report (written by Anne Jenkins) has been completed. Regarding the *Young Men's Journey*, cards have been tested and a qualitative assessment has been conducted in several countries. PATH will next be doing a quantitative assessment.

Dominican Republic study. Tabitha reported that this project is still on hold and that she will send out an update when she receives it.

Global Dissemination Conference. The Communications Team proposed the following potential contributions to the conference: the 3 case studies, inventory/ database of M/RH projects (expanded to include projects not funded by IGWG); and data from JSI task force's review of gender-sensitive programming in RH and its impact on gender equity and RH.

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Jeff Jordan, Futures Group International, Chair of IGWG TAG: Update and discussion on IGWG TAG and future directions

Jeff began by explaining the structure of the IGWG Steering Committee, which includes 7 CAs and 14 staff. The AID Co-Chair is Michal Avni, the CA Co-Chair is Jeff Jordan, and the Coordinator is Diana Prieto.

Jeff reviewed the 2 primary, ongoing functions of the IGWG: dissemination (through Measure Communication) and training (through the POLICY Project). M/RH work and products are to be incorporated into the dissemination and training functions of the IGWG.

In addition, the IGWG no longer sponsors working groups, but now has task forces. The task forces are technical, topical, and created for a specific purpose, with discreet activities, then dissolved. Topic areas include GBV, HIV/AIDS, Adolescents, and Male Involvement. Current task forces include: Gender and AIDS, Gender and Quality, Evidence-Based Programming, and Implementation Guide. The TAG made recommendations to AID as to which task forces should be funded, and is awaiting reply.

Karin Ringheim made the suggestion that the minutes of the TAG be posted to the listserv, and Michal encouraged SC members to add themselves to the IGWG listserv. Sam and/or Victoria will send a message advising members to do so.

Jeff suggested the inventory/database of gender projects be included in the funded proposal. Michal will talk with PRB so that they include it in their work plan for next year. It should include past and current projects, and could be linked to AID CA work plans. It could also be posted to the IGWG website. Jeff will raise the issue at the next TAG meeting.

Jim McMahan raised the concern about points of entry and opportunities for participation for those not involved in the TAG. Judith Helzner echoed his concern of not marginalizing interested, new, and even continuing participants of the M/RH SC. She raised the question of how to salvage the energy, work, and commitment of participants under the new structure. Jeff Jordan replied that the same exchange of the M/RH SC may continue and is encouraged to do so, but that funding for its operations would not continue. In response to a comment by Judith, a discussion ensued regarding whether the gender focus is being "shelved" because it is still not viewed as integral to health and development programs (in contrast to the MAQ subcommittee, which continues to be funded. However, Maw's funding is also apparently under scrutiny).

Returning to the issue of the IGWG TAG structure, Jeff Jordan named the 7 non-CA members of the TAG: Lori Ashford (PRB), Belies Giorgio (Advance Africa), Meg Greene (PAI), Jodi Jacobsen (CHANGE), Jeff Jordan (TFGI), John Townsend (Population Council), and Ellen Weiss (ICRW). In addition, there are representatives for each of the regional bureaus of USAID.

Diana Santillan inquired as to how the organizations on the TAG are selected and whether or not they rotate. They are selected according to area of expertise, representation of non-CAs, previous involvement in the SC, and regional focus.

Julie Pulerwitz encouraged the SC to continue the Speaker Series, with in-depth discussions following speakers'

presentations. Jeff Spieler noted that the TAG views the speaker series as its domain (and, therefore, no need for the SC to do it), and that the TAG should be held accountable for this. In addition, Michal announced that the TAG will host a day-long seminar on GBV and RH on April 29 or 30 (TBD). It will focus on field perspectives, with speakers from developing countries.

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Pat McCann, Director of Outreach, Men Can Stop Rape: Update on MCSR dating violence prevention effort for young men in DC public high schools

Pat McCann began by reviewing the goals of the "Strength Campaign", which included: to educate young men about their role as allies with women in preventing dating violence; to promote positive, nonviolent models of male strength; and to empower youth to take action to end dating violence, promote healthy relationships based on equity and respect, and create safer school communities.

Next, McGann described the components of the campaign: Metro bus and bus shelter ads throughout DC; posters in all DC public high schools (7 different posters); "REP" magazine for students created around Campaign themes ("My Strength is Not for Hurting"); guidebooks for school faculty and staff; and "Safe and Strong" workshops with students in selected schools.

In order to assess the impact of the Campaign on students and school "influencers", MCSR adopted a pre-posttest with control group model. The original questionnaire measured the impact of the workshops (conducted in 3 high schools) specifically, and the campaign as a whole more generally.

Dimensions of the evaluation included campaign exposure and recall; change in attitudes; and behavior change.

Summarizing the key findings, McGann noted that there was significant exposure to and recall of the campaign. Results were mixed in terms of attitude and behavior change, and workshops were shown to have a positive impact on student awareness and self-efficacy.

MCSR works to address the root causes of sexual violence, defined as the attitudes, norms, and behaviors that cause individuals to see someone as less than human. Their view is that violence prevention and risk reduction often puts women in a defensive position, leaving it up to them to prevent such attacks. In contrast, the basic assumption on which they operate is that men can influence other men and speak out against dehumanization.

MCSR contact info is: (202) 265–6530; info@mencanstoprape.org; www.mencanstoprape.org

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Lori Ashford, Population Reference Bureau: Discussion of planned IGWG dissemination activities

Lori passed out a sheet of "PRB Dissemination Work: IGWG Projects" to all participants. She emphasized three major issues: the website; how to expand the IGWG audience; and how to better strategize for enhanced dissemination.

Regarding the website, Lori reiterated that the IGWG site is housed on Measure Communication’s site, and emphasized that all IGWG documents should be on this site. There is also a need for better coordination for more consistency

between the M/RH and IGWG websites. (This will be discussed with the PRB staff who maintain the IGWG website, and Sam will facilitate the effort.) Jeff Spieler suggested the IGWG website should be the predominate site. Julie suggested the possibility of putting the searchable database of gender projects on the IGWG site. A question was raised as to who would update and maintain the database. This will be discussed at the next TAG meeting. Sarah Martin volunteered to assist in the effort.

In terms of expanding the mailing list audience (which is currently at about 200), Lori proposed reflecting on whom we want to reach, what we want to get to them, and how (through what and how many types of media). She noted that 200 is not a cost-effective number. Jeff Spieler requested to see the list of 200 current names. He and others will review the list. Sam will send out a message to encourage people to join the IGWG listserv. Michal sent around a list requesting suggestions of individuals and organizations to receive IGWG products (to be added to the mailing list). In addition, Jeff suggested including a small "ad" in journals such as *PIP, Studies in FP, Network*, etc.

Victoria underscored the need to identify who and how to coordinate with PRB to ensure future dissemination. Lori called for a few key contact persons for dissemination and the website. Sarah Martin volunteered.

Lori also pointed out that there needs to be better strategizing for dissemination of IGWG products. She noted that PRB needs to be involved earlier in the process, and that planning for dissemination should begin as early as possible in the life of a project. The issue of how to disseminate the OG and other SC products (by CD-ROM, e-mail, etc.) was also raised.

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Brainstorming/plans for SOTA M/RH dissemination conference

Sam began the session by distributing the proposal for the conference to those who did not have a copy. He explained that the conference would be a collaborative effort among PATH, EngenderHealth, and PRB. As for funding, the SC could use all unobligated funds ($35,000) for this conference, and $100,000+ additional would need to be raised (in addition to the $40,000 requested from the IGWG).

Victoria noted that, while the proposal focuses on the conference, it actually entails 3 distinct products: the conference itself, an implementation guide ("how to"; where to get resources; and best-practices compendium); and a summary conference document.

Next, the session was opened up for comments. Karin voiced the opinion that the budget was insufficient. Sam replied that the idea is that each participating organization would submit their presentations with notes ahead of time, which would result in less work to develop the implementation guide.

Jeff S. underscored the importance of involving those "not yet converted" (from 6–7 priority countries, for example). AID, World Bank, and UNFPA priority countries could be considered as possible countries to focus on. This would also raise the possibility of field support. However, Judith stated that she thinks it is also important to have some "converts" there, as they can still benefit from the discussions and products (IG and conference paper).

Jay Gribble mentioned the need for presenters to specify how to apply lessons learned in various contexts, and to make the conference and the IG practical, useful, tools adaptable in diverse settings.

Jim McMahan suggested considering Bangladesh as a priority country, as they have a national gender equity strategy. He also suggested the possibility of having country strategies to be rolled out as an end result of the conference.

Michal questioned to what extent the conference might incorporate health issues beyond RH. Judith Helzner referred people to the 6 priority topics listed on page 7 of the proposal: Gender and Adolescent Male Socialization and RH; Gender and Men and FP and RH; Gender and Men and STI/HIV/AIDS and Dual Protection; Gender and Men and Maternal and Child Health; Men and GBV; and Gender and National and Multinational Uniformed Services.

Manisha cautioned against creating roll-out strategies that die due to lack of funding. She mentioned that participant selection is also important. Victoria added the importance of identifying donors who would follow through with participant teams. Alfred Yassa recommended holding follow-up meetings in each participating country to assess progress after one year. Victoria emphasized the need for specific, concrete, and implementable strategies.

Judith suggested the proposed timeline for the conference may be overambitious. Sam and Manisha and the organizing agencies need to meet to discuss how to involve others without holding back the progress of the planning. Participants agreed they will try to negotiate with the TAG for more time to plan the conference.

Diana Santillan mentioned JSI/EWRP's ongoing review of gender-sensitive programming and its links with RH. One component of this is male involvement. It includes a summary of projects, description of the evaluation of each, and impact on gender equity and RH. Karin suggested using this data as a starting point.

Manisha asked for volunteers to be involved in planning the conference. Karin, Jay, Judith, Alfred, Julie, and Jim all agreed to assist. In addition, a message will be sent out to the larger group to give others the opportunity to participate.

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Updates re: selected M/RH and related CA activities/other business

1. EngenderHealth (Manisha)—Draft versions of Part 2 (couple counseling and involving men) and 3 (diagnosis and treatment of male RH problems) of the Men & RH manual are available for review. Final, printed versions should be available in 2–3 months (and in about one month electronically).
2. Steve LaVake (YouthNet)—The new YouthNet project, directed by Nancy Williamson, focuses on RH promotion and HIV prevention among 10–24 year olds. It is a five-year project that will identify 5 focus countries and will work in a total of about 32 countries. Partners include DTT, CARE, FHI, and MSI.
3. Jill Gay (Consultant)—Jill and Karen Hardee are working on the "What Works: A Program Manager's Guide to Effective Evidence-Based RH Interventions" manual, which is a review of published literature. Jill is currently working on the HIV/AIDS chapter and called for additional resources. Sarah Hawkes, who is conducting a meta-analysis of HIV (to be published soon) was suggested as an important contact person.
4. Jay Gribble (IRH/Georgetown)—Introduction of the Standard Days Method of FP is underway with PCI/El Salvador's water and sanitation program. Jay presented quantitative data and mentioned that qualitative data will be analyzed next. In his presentation, Jay examined the question "Machismo Attitudes in El Salvador: Myth or Reality"?
5. Mark Austin (Gender and HIV task force)—the G/HIV task force met on February 26. They have completed a series of interviews with AID personnel and CAs working in gender and HIV to get an idea of key issues and programs. The initial analysis has been written. Next steps include workshops to present findings on how to integrate gender in HIV/AIDS. Men's roles and male involvement were consistently brought up. Missions are very aware, but male involvement and gender equity are less understood, though male involvement is on the minds of field programmers. Issues examined included prevention, testing and counseling, and care and support. The conclusion was that the message is getting to the field and to programs. Data analysis continues and a draft for circulation will be ready in a few months.
6. Diana Santillan (JSI/EWRP)—A project is underway in Vietnam, which involves a peer education intervention to develop life skills among youth. JSI is examining gender attitudes and RH intentions. They recently completed the baseline, and questionnaires are available for review.
7. Kathleen Taylor (PAHO)—Male Involvement and RH project is beginning. On March 19–21, the first meeting

will take place in Nicaragua, in order to train researchers. The research phase will last 6 months, and results are expected in 8 months. Gary Barker developed the research protocol and will train the researchers. Kathy invited volunteers interested in reviewing the Spanish protocol to contact her.

8. Alfred Yassa (JHU/CCP)—"Together for a Happy Family" campaign in Jordan was evaluated in 2000 and the report is being finalized. It will be ready in about 4 months. Dr. Yassa presented summary results of the evaluation. The Jordan program is now working on a peri-marital and newly married guide to be reviewed, pre-tested, and tested.
9. Sam Clark (PATH)—Sam shared several useful resources with the group, including the following: Working with Young Men to Promote SRH: Safe Passages to Adulthood (Kim Rivers and Peter Aggleton); AGI's Chartbook, "In Their Own Right" Addressing the SRH Needs of American Men"; the Japanese development society's newsletter; PASHA—"Wise Guys" curriculum, and Santa Cruz County male involvement project; Gary Barker's 5 workbooks for young men (addressing the topics of Mental Health; Violence; HIV/AIDS; Paternity/Fatherhood: and SRH) to be translated to English. They will eventually be downloadable from the Promundo website.

In addition, Sam discussed 3 PATH projects in China; one involving migrant workers and RTI prevention; another, a male-oriented condom hotline; and a third, a couples survey, in which the outcome variable was reduced abortion. Sam also mentioned that the RHO website content has been translated to Chinese and is posted on a website in China!

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Next meeting/Plus-delta exercise/Adjourn

The next meeting is planned for the week of May 13 or May 20. An e-mail will be sent to people soon to inform them.

Plus (to do again next meeting)

- Sam's "positivity"!
- Timely/timekeeping
- Speaker/presentation
- Location
- CA updates

Delta (to change)

- Alarm system
- Would like to see more emphasis on how to move field ahead
- Too much time spent on "process" issues

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For more information

For more information, please review the minutes of other past Subcommittee meetings.

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IGWG Men and Reproductive Health Subcommittee

Meeting Minutes: July 25, 2001

- Attendance and logistics
- Report of the working teams to the committee
- Workplan discussion and budget update
- Other announcements
- Presentations
- Update and discussion on IGWG M&RH subcommittee restructuring plan
- Updates on other selected CA activities
- Update on orientation guide and new products
- Next meeting/Plus-delta exercise
- For more information

Attendance and logistics

The meeting was held at Georgetown University, from 10am to 5pm. Attending were: Erin Anastasi (Georgetown/IRH), Mark Austin (USAID), Michal Avni (USAID), Anna Benton, (CHANGE), Lucretia Brosey (consultant), Michèle Burger (Consultant), Sam Clark (PATH), Nick Danforth (Consultant), Anne Eckman (Consultant), Jill Gay (Consultant), Meg Greene (PAI), Jay Gribble (Georgetown/IRH), Ruth Goldstein (Wesleyan), Judith Helzner (IPPF), Victoria Jennings (Georgetown/IRH), Mihira Karra (USAID), Tabitha Keener (USAID), Ann Leonard (Consultant), Sara Martin (JSI), Minna Nikula (Georgetown/IRH), Emma Ottolenghi (PopCouncil), Diana Prieto (USAID), Julie Pulerwitz (Population Council), Karin Ringheim (PATH), Saira Saeed (Consultant), Diana Santillan (JSI), Jane Schueller (FHI), Myrna Seidman (Georgetown/IRH), Jeff Spieler (USAID), Kathy Taylor (PAHO), Mary Nell Wegner (EngenderHealth), Claudia Velasquez (Georgetown/IRH)

Victoria Jennings, new co-chair of the Men and Reproductive Health Subcommittee, hosted the meeting, held at Georgetown University. She welcomed participants with a brief history of the Warwick Evans room where the meeting

took place. Sam Clark, co-chair, then distributed the "blue fact sheet" on the subcommittee and asked participants to introduce themselves. The two working teams, Communication & Dissemination and Research & Evaluation, then met for an hour and reported back to the subcommittee. New members were invited to attend one of the two working team meetings.

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Report of the working teams to the committee

Communications Working Team

Mary Nell reported for the Communication and Dissemination working team.

Speaker Series. Wayne Pawlowski will facilitate a day-long sexuality training workshop on August 15th at AED. The purpose of the workshop is to train members of the IGWG and interested USAID and CA staff on how to discuss issues of sexuality and incorporate sexuality in our programs. Sexuality training was a recommendation that came out of the Population Council's Power in Sexual Relationships meeting. Wayne Pawlowski is the current Director of Training at Planned Parenthood Federation of America. He is a nationally and internationally recognized reproductive health care/ family planning trainer, educator and counselor. Mary Nell thanked the Population Leadership Program for financial and logistic assistance to the subcommittee in hosting the Sexuality Training session. She also thanked Michelle Burger, who has been handling this.

Mary Nell reported that Dean Peacock of the University of California at Berkley, Lori Heisi or Mary Ellsberg will present on Gender-based Violence with a focus on advocacy and policy issues. The date has yet to be determined. Lori Heisi has agreed to speak at the next Subcommittee meeting in November; participants agreed that the best date for a longer presentation would be better determined at that time.

Orientation Guide Update. The OG has now been pilot tested in 14 organizations in Boston, New York, Washington and North Carolina. Recipients' evaluations and facilitators' feedback were summarized by Michelle Burger with help from Meg Greene. An all day meeting was held on July 24th at Georgetown University with those who had facilitated the presentations as well as two representatives who hosted presentations, to determine next steps. The discussion was based on results from recipients' evaluations and facilitators' feedback, which were summarized by Michèle Burger, Meg Greene, and Diana Prieto. See Item VIII below re "Update on the OG" for recommendations and decisions made at the meeting.

Research and Evaluation Working Team

Meg Greene, reported for the Research and Evaluation Working Team

Status of Case Studies. Meg Greene updated the team on the status of the case studies and distributed a sheet on some decisions that needed to be made, some of which were discussed earlier in the morning by the reviewers. As background for new members, she described that the case studies were being developed in response to feedback from CAs that there were few models of behavior change and male involvement in the literature. The model for these case studies is the very reader-friendly "Qualite" publication put out periodically by the Population Council. The working team identified three innovative program strategies, which, although they lacked formal evaluation, were consistent with the subcommittee's core values, useful in getting men and boys (and women) to question their assumptions regarding gender norms, and worthy of further replication and testing. The three NGOs selected were addressing issues related to the subcommittee's three themes, violence (Salud y Genero, Mexico), Adolescents (Society for the Integrated Development of the Himalayas, India) and dual protection (Stepping-Stones, Africa and Asia). Jeff mentioned that there has been much discussion in

Uganda about the contribution that the Stepping Stones program played in promoting behavior change that resulted in reductions in HIV incidence, delay of sexual initiation and decline in number of partners. Meg said the entire Stepping-Stones manual is quite impressive and one can see how participation in these exercises could permanently change one's views.

A draft has now been received from the authors of two of the three case studies, Stepping-Stones and SIDH. Draft three of the SIDH case study has just been received and will be sent out to reviewers. Hopefully, it is now close to being ready to send to PRB for copy editing and layout. Pictures have been received and the text is an appropriate length. The Salud y Genero case study was due in May and Meg has drafted an urgent appeal to the organization to complete this. PRB has already received funds from the Subcommittee, which will be used to produce and distribute the case studies. In addition to the comprehensive PRB mailing list, we discussed other potential recipients. Tabitha will send the case studies to missions through the internal mail. Other suggestions should be sent to Meg.

Thematic Position Statements. The working team drafted position statements on the three priority areas of Subcommittee work for the benefit of those who wanted to know about the work or submit proposals that were consistent with the Subcommittee's three thematic goals. The statements had to be reviewed by numerous people and vetted through a long process. The dual protection statement is now on the www.rho.org Men and Reproductive Health website (supported by the Subcommittee). The Gender Based Violence (GBV) statement is close to being finalized. The adolescent statement may take some additional work because it is framed in terms of meeting the needs of adolescent boys rather than as a statement about gender norms and socialization as originally envisioned.

Indicators. The Men and RH indicators were drafted by Nancy Yinger and Elaine Murphy and also posted on the RHO website. Previously, there had been discussion around having Tim Williams of JSI develop some additional programmatic indicators for illustrative purposes so that CAs could more readily see how to operationalize male involvement in their programs. Tim was not at the meeting but Julie Pulerwitz of the Population Council suggested there might be still time to have input into the indicators used in the gender study underway through Frontiers in Bolivia. She will follow up with the Frontiers staff.

Positive Deviance Study. The Subcommittee is providing support to replicate, in the Dominican Republic, an exciting new protocol that was developed for use in Mexico to study positive deviance with support from the Moriah Fund. Sandy Garcia is the PI. Those interested in receiving a copy should send an email to Tabitha at: tkeener@usaid.gov. The focus of the study is on factors contributing to successful condom use.

Evaluation of products. The committee is supporting the development of a version of the PATH game for young men entitled *Safari of Life Game—A Young Man's Journey*. Jeff asked if we had also funded evaluation of the game. Karin said that the proposal included pre-testing but no field-testing. The original Safari of Life was recently field tested in Kenya. Sam has discussed with Sam Taylor the possibility of testing the game in the United States. Jeff suggested that it would be worth investing additional funds for field testing in 1–2 countries.

The working team has previously recommended that all proposals have an evaluation component built in. When the CD-ROM *HIM* was issued, Meg Greene and Megan Drennan developed an evaluation form, which was included with the CD-ROM but the Subcommittee has not been informed of the response to this form (there was not a JHU representative at the meeting). JHU/CCP submitted a proposal to evaluate the CD-ROM *HIM*; the proposal was approved with a request that JHU revise the evaluation instrument. Jeff said there were a variety of activities that could be evaluated. For example, Margaret Sanger has produced a teaching tool for working with men.

Meg said that she would like to step down as chair of the R and E working team once the case studies are completed, by the end of the year. She asked team members to be thinking about her replacement. Jeff suggested that the restructuring of the IGWG and Subcommittee might mean that the R and E team would be replaced by another type of team.

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Workplan discussion and budget update

Sam reported that the Subcommittee is close to having all present funds committed. The need to plan ahead and submit viable proposals by November was stressed. The Subcommittee should define what it wants to accomplish and CAs will propose to take the lead on particular projects. The IGWG TAG will review these. The budget group meets in February and funds will become available to the recipients in June. Tabitha said that in the meantime, between $10,000–$15,000 remained available for innovative ideas. Michal said that interest in male involvement is very high, but stressed the need for concrete ideas and implementation plans. Jeff said the subcommittee/IGWG budget cycle is the same as for the CAs. As USAID learns what its budget will be, it will ask the Subcommittee to prioritize its proposals. Under the new administration, USAID is being restructured and the Center for Population, Health and Nutrition will now become a Bureau. It is unknown how much money will be allocated in FY’02. Five million dollars were set aside for special initiatives, including the IGWG, in FY 01. Proposals from the Men and RH Subcommittee will compete with all other proposals for available funds. Because there will not be another meeting before proposals are due, the discussion of workplans and development of proposals will need to be conducted through additional meetings and conference calls. Members are encouraged to think of ideas related to the three thematic areas.

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Other announcements

Introduction of PAHO representative

Jeff introduced Kathy Taylor, a new Michigan fellow working in the women’s health and development division at PAHO. She will be working on the male involvement in RH study that Martine de Schutter, former PAHO representative to the Subcommittee, reported on last year. With funding from GTZ, PAHO will conduct a 4-year study in 7 countries. Programs will be implemented in Belize, Panama, Costa Rica, Guatemala, El Salvador, Nicaragua and Honduras. Formal evaluations will be conducted in the last four countries.

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Presentations

"Masculinities and Reproductive Health": a presentation, interactive exercise, and discussion with Michael S. Kimmel

Judith Helzner introduced Michael Kimmel, Professor of Sociology at SUNY at Stony Brook, NY, and Editor of the Journal, "Men and Masculinities". This journal is available from Sage Publications and is on their website.

Kimmel started by assessing the gender composition in the room. The majority of the participants of the M & RH Subcommittee meeting were women. This is what is faced when we talk about men. Gender has been under discussion only in the past 30–40 years and mostly by women. Only recently has it been considered a fundamental experience of social life. The problem remains that gender is invisible to men. We need to look at the points of entry for men in the gender discussion and make masculinity visible. "Privilege keeps the terms of your privilege invisible". It is important to start the discussion at privilege instead of at men's experience of powerlessness.

When we speak of making gender visible to men, we do not speak to a singular identity. We have to start with an

understanding of difference. Kimmel recommended a UNDP document on masculinities that is available at: www.undp.org/gender.

Kimmel then discussed what he terms as the "Rules of Manhood". If manhood is a construction, what does it mean? He acknowledged that this is U.S.-centric. 1. "No sissy stuff"—don't do anything that hints at the feminine. 2. "Be a big wheel"—wealth, power, status. 3. "Be a sturdy oak"—reliable in a crisis. 4. "Give 'em hell"—take risks, go for it.

The definitions of what it means to be a woman has changed dramatically over the past 30 years. However, when boys are asked now what it means to be a man, they generally give the same answers as were given in the 1950s.

The rules can be used as tools to condense themes for discussion.

Rule 1—No Sissy Stuff: Highlights how our work with adolescents is so important. Boys want to be seen as "manly" by other boys. When boys are 8–9 years old, they start to find their voice, through posing, false bravado, etc. There is a constant fear of losing control, being over-powered.

There was a question raised as to how universal this is. Michael said he could not speak globally, but gave an example of boys in South Africa and harassment of women, which is done as posturing in front of other boys.

Rule 2—Be a Big Wheel: The entry of women in the workplace has been seen (by some) as an invasion. Men feel gender equality is a loss to men. Threatens the sense of entitlement. She took "my job."

Rule 3—Be a Sturdy Oak: This has implications for health-seeking behavior. Masculinity prescribes being out of touch with one's body, not concerned for personal safety. Masculinity is a fundamental risk factor for men and women. Example: HIV and dual protection. "Safe" and "sex" is an oxymoron. It is asking men to stop having sex like "men". The word "safe" is coded as feminine. The response of the gay male community addressed this by making "safe sex" sexy. Need to emphasize the pleasure aspect in dual protection messages.

Rule 4—Give 'em Hell: Direct implications on violence. Regarding gender-based violence, we know from research on domestic violence that men (generally) do not hit their wives when things are going well. It tends to happen when she doesn't do something, when his entitlement has been challenged. The violence occurs to restore power. To raise issues of gender-based violence, we must raise the issue of entitlement.

Points of entry for future conversations with men. To get men over 25 years old to talk about gender, you must focus on the positive parts of masculinity. For example, fatherhood and the idea of protecting your family are good introductions. It is valuable to get men to think that discussing gender is not just "male bashing" or a negative critique of men. Fatherhood is a unifying factor for a large number of men and men tend to respond to this. (See the website, www.dadsanddaughters.org)

It is important to recognize the significance of age and generation differences. The new generation of feminists (3rd wave) takes the previous struggle of feminism for granted. This new generation is much more interested in individual efficacy and power. What they have to offer to the previous generation (2nd wave) is cross-gender friendship and coalition-building skills with people with whom they may not always agree.

Kimmel then engaged the participants with an activity of what it means to be in the box of "masculine" and what words we use for individuals that are outside of the box (fag, wimp, pussy, etc). Responses to being identified as being outside of the box can be extreme: suicide, depression, overcompensation with violence etc. It is not safe to stay in the box, with traditional masculine behaviors (of the sturdy oak, etc) and, at the same time, it is not safe outside of the box.

We must take homophobia very seriously. Homophobia is the fear that someone will label you as gay. The need to avoid being seen as a "gay" by other men/boys is very strong. Posing and not showing weakness starts very early.

It was suggested that it is much easier today to raise a girl that is strong and confident than it is to raise a boy who is sensitive and caring.

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Presentation on "Baseline Findings from the India Men in Maternity Project," by Emma Ottolenghi, FRONTIERS/Population Council

Emma Ottolenghi of FRONTIERS spoke about the Global Agenda "Men in Maternity Services or MiM" study being conducted in Delhi, India and Durban, South Africa. She described the study, its research design, site characteristics, components of the intervention, goals, objectives and research questions.

The second portion of the presentation consisted of a series of preliminary results (not for quotation) obtained from 486 interviews with pregnant women in 3 control clinics in Delhi. (Men will only be interviewed pre-intervention in the intervention clinics). The results presented included: 1) a socio-demographic description of the women and their husbands (as reported by the women); 2) family planning knowledge, past use and intentions to use after this pregnancy; 3) general RH knowledge including danger signs in pregnancy, fertility awareness, breastfeeding and LAM; and 4) STI and HIV-AIDS knowledge and reported risk behaviors of either the woman or her husband. Finally, there were data on male involvement, including supportive behaviors, financial support, decision-making in the couple, and desires of the women to have their husband involved in clinical services. The study is also collecting data on gender-based violence but these data were not ready for this preliminary discussion.

The India study is now interviewing women and husbands in the intervention clinics. In South Africa, they have not completed the control clinic women's interviews. When sets of data from couples interviewed become available, Emma said they would be glad to present both a comparison of what women and men say as well as concordance within couples. Both women and men will be interviewed separately again at six months postpartum (or six months after the index pregnancy was due to be at term, in cases when there was a pregnancy loss) in their home.

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Update and discussion on IGWG M&RH Subcommittee restructuring plan

Sam Clark quickly reviewed the reorganization plan that Michal presented at the May meeting and then reviewed the presentation he made to the IGWG last month that outlines the Subcommittee's core values, accomplishments and proposed changes. Sam underlined the importance of finding more efficient ways to make decisions, monitor and evaluate the proposals funded by the Subcommittee, and develop state of the art field-oriented products. The recommended structural changes for the Subcommittee include adopting working groups that focus on the three themes and being more inclusive of the IGWG community at-large.

Victoria Jennings facilitated the discussion with a focus on how to work more closely with other members of the IGWG. Everyone acknowledged the volume of products developed by the Subcommittee. With regard to the Subcommittee being a think tank, several members considered the value/outcome of such an excellent presentation as the one that Michael Kimmel provided in the morning. How can members act on today's presentation? What can we do with it? Victoria suggested adding homophobia to the Subcommittee's theme statement.

Jeff Spieler talked about creating a task force around re-defining masculinity, hiring Michael Kimmel as a consultant and

developing a masculinity project in Botswana, for instance. In response to concerns about funding being controlled by one agency, Jeff and Diana suggested that CAs might get together as a team and work on a given project.

Several members raised concerns about funding issues and differed with the perception that most of the work is done by outside paid consultants. Karin Ringheim, Meg Green and Mary Nell Wegner provided examples of the extensive time and work they have contributed in-kind to the Subcommittee. They indicated that higher levels of productivity are unrealistic when some people are being funded and others are not.

Members then considered how IGWG members could have benefited from this morning's presentation. Members agreed that these meetings and the presentations should be open to the entire IGWG. The discussion moved toward considering the possibility of substituting the quarterly meetings with a speaker's series and having annual business meetings. Time did not allow further discussion to consider this format nor to get a sense of whether it was acceptable to Subcommittee members.

There was consensus that the Subcommittee, which was created to influence USAID to support male involvement initiatives, succeeded in pushing the IGWG on men and RH issues. Before concluding the discussion, Victoria asked members to consider "who is not around the table." This elicited further discussion about funding issues, and how funds may drive who is and who is not active in the Subcommittee.

The session ended with members voicing concerns about transitioning from work teams into theme-based task forces. They agreed to merging the Men and RH Subcommittee mailing list with the IGWG mailing list and to end these parallel structures, but were not clear on who would do this and when.

Finally, members expressed serious concerns about developing proposals in time to meet the November deadline, since the Chairs had not seen the new format for the proposals and the Subcommittee will not meet again until November. A draft of the proposal was distributed at the Steering Committee meeting in June; Diana will re-send that draft (and any subsequent drafts).

Before the meeting ended, members agreed to meet at 8:30 am on August 15, when several members will be attending the Sexuality Training Workshop, to work on proposals.

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Updates on other selected CA activities

IPPF/WHR

Judith Helzner informed the Subcommittee of the Working Group Meeting on Men as Partners for Gender Equity that IPPF/WHR hosted with partial support from the Subcommittee.

Judith described how impressed she was with the youth that participated and the important contribution they made to this meeting. For instance, it was the first time the Adolescent module of the Orientation Guide was presented to youth and it was clear that the module was designed for adult providers rather than with peer leaders or youth promoters. However, the young men attending this meeting were eager to work with the Orientation Guide and adjust the language to make it youth-friendly. Judith also relayed the enthusiasm with which the Orientation Guide was received and the urgency to release it in its current version. The representative from Tunisia wants to use it at a meeting in October and regional representatives from Asia were eager to collaborate on a meeting where they would present the OG to their constituencies.

Judith then reported on the meeting that AGI hosted to bring together an advisory group as AGI begins to work on an

"international chartbook" on men's RH. In her report, she underlined AGI's reliance on DHS surveys in contrast to advisory members urging of AGI to consider additional sources that also provide qualitative information.

Institute for Reroductive Health

Rebecca Lundgren (IRH, Georgetown University) provided an update on projects in India and El Salvador:

Introducing the Standard Days Method into the Reproductive Health Programs of CASP-PLAN and CARE, India. The objectives of these projects are to test the introduction of a new fertility awareness-based family planning method into community-based reproductive health programs. CASP (Community Aid and Sponsorship Program)-PLAN provides family planning services through Community Health Guides in urban slums of New Delhi, while CARE provides FP education and services through community volunteers in rural villages of Uttar Pradesh. Both projects use an experimental design to test whether involving husbands in method counseling and follow-up has any impact on the number of new users, method satisfaction, correct use and continuation. The project will be completed in about one year, and baseline and preliminary results could be shared by early 2002.

Incorporating the Standard Days Method into Water and Sanitation Projects in El Salvador. This project is being conducted by Project Concern International in El Salvador. In an effort to involve men in family planning, they are incorporating family planning outreach and referrals into water and sanitation projects. They are also training community volunteers to provide the Standard Days Method. This strategy was chosen because baseline research from the water projects suggested that men were interested in using a natural FP method, and indeed many already use some kind of periodic abstinence. This project also uses a quasi-experimental design to test the impact of male involvement on method uptake, correct use, continuation and satisfaction. (Same time frame as above, except baseline data has already been completed.)

Sexuality Training

Tabitha Keener announced that the Sexuality Training Workshop will take place on August 15.

Liaison

Sam informed the Subcommittee that the IGWG is looking for a person to be the liaison between the Men and RH Subcommittee and the Gender and HIV/AIDS Task Force. Anyone interested in volunteering for this position should contact Sam, who can provide a description for this position. [Mark Austin of USAID has since agreed to take this on.]

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Update on orientation guide and new products

Orientation Guide

Mary Nell presented the outcomes of a meeting held the previous day, July 24th, to agree on the next steps for the Orientation Guide. Detailed minutes from the July 24th meeting are available from Diana Prieto or Michele Burger.

Revisions. The guidelines for revisions include: no additional slides, and changes to the text under the slides will be limited based on the feedback from evaluations and facilitators. Cosmetic and some contextual changes can be made to the slides themselves, also based on the feedback received. Notes for facilitators will be integrated into the Orientation Guide. Revisions will also include bolding text that underlines the main idea of a given slide. However, in cases where it

is difficult to discern one main idea over another, a team may decide not to bold any text.It was agreed that teams would work on individual modules and every effort would be made to include the original authors, whenever possible, into these teams. The deadline for submitting revisions to Michele is September 15.

Jane Schueller offered to have one of her trainers read the revised version for content and flow as well as for suggestions of where to insert interactive activities. The final version will be reviewed by Michèle and other key members of the Subcommittee (to be determined).

Audience. It was agreed that the Orientation Guide is relevant to a broad audience, given the agreement that users can adapt it to their needs. However, the facilitators' notes will urge presenters to know their audience prior to presenting modules so they can adapt their presentation to their audience's knowledge, interests, culture, etc.

Proposed **strategies for disseminating the O.G. in the field** include: offering it to missions when staff goes on TDYs; presenting it at annual meeting of PHN teams (which tend to include local partners); encourage members of the Subcommittee to disseminate it to their field offices; look for opportunities to present it at meetings, distribute it to academic institutions, both in the United States and abroad.

The consensus, however, was that the Orientation Guide should be modeled by a facilitator and then released to participants who attend a given presentation rather than distributing it by mail or over the Internet.

It was also agreed that a limited number of the current version would be released immediately to selected individuals who have requested it. In exchange, these recipients will be asked to complete a newly revised evaluation form. The release of these copies is considered Phase II of the pilot test, by testing it in the field. Facilitators will let Michèle know the number of copies they need.

The committee will ask JHUCCP to make the additional copies and will get an estimate from them for the cost of producing a talking head version of the CD-ROM. Also, Michèle reported that UNFPA has offered to translate the guide.

Update on New Products

New products under consideration include a conference or workshop to share state of the art programming, and the production of monographs and a power point presentation based on the papers presented at the conference. Other suggestions were: a mechanism to track the use of the guide, a clearinghouse for programming information on men and reproductive health, and technical assistance to organizations.

The suggested audience for the conference includes: USAID, CAs, chiefs of party, the research community, donors, representatives from the "South", the RH and HIV/AIDS community, influential people within CAs, UNFPA, and IPPF (among others to be determined). No decision has been made regarding the number of participants. Mihira Karra urged organizers to make sure that the appropriate audience is targeted and that we reach beyond those already working with men as participants. Michèle Burger suggested inviting Ministers of Health and senior staff of bilateral donor organizations.

Two scenarios were considered in terms of the timing of the conference. If it is supported with USAID funds only, the conference could occur in the fall of 2002, given the funding cycle. For the conference to be held earlier (end of 2001) would require leveraging "seed" money from another source. These funds could be combined with Men and RH SC funds that have not been obligated. Tabitha reported this could be up to 15K, but the amount actually available is not certain.

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Next meeting/Plus-delta exercise

The next meeting of the Subcommittee will be on November 15 at AED. Lori Heisi will be presenting on Gender-based Violence.

Plus (to do again next meeting)

- Co-chairs did a great job.
- Michael Kimmel was an exceptional presenter.
- Wonderful space. Participants had no trouble finding it & getting there.
- Judith and Michal's work on planning the OG debriefing meeting resulted in its being so productive.

Delta (to change)

- Include time in the agenda to discuss actionable items immediately after a presentation.
- Ordering lunch. People did not RSVP about ordering lunch, so it was difficult to estimate the lunch order.
- Too much information in a short time.
- Keep more focused on results.
- Have to be conscious of avoiding becoming a talking box and think about how to relate the work of the Subcommittee to country programs. How to increase participation of CAs as well as developing country participants?
- Don't revisit restructuring at the next meeting. Have a small group grapple with this issue.

IGWG Men and Reproductive Health Subcommittee

Meeting Minutes: November 15, 2001

- Attendance and logistics
- Report of the working teams to the committee
- Workplan discussion and budget update
- Update on IGWG meeting and M&RH subcommittee proposal endorsements and submissions
- IGWG Men and RH Speaker Series presentation on gender-based violence
- Discussion on men and GBV: What role for M & RH SC?
- Updates regarding selected M/RH and related CA activities/other business
- Next meeting/Plus-delta exercise
- To do in the interim
- For more information

Attendance and logistics

The meeting was held at the Academy for Educational Development (AED), from 9 am to 5 pm. Attending were: Erin Anastasi (IRH/Georgetown), Mark Austin (USAID), Suzanna Banwell (CHANGE), Anna Benton (CHANGE), Michèle Burger (Consultant), Sam Clark (PATH), Laurette Cucuzza (CEDPA), Mary Ellsberg (PATH), Paul Feldblum (FHI), Jill Gay (Consultant), Meg Greene (PAI), Jay Gribble (IRH/Georgetown), Sarah Heaton (CHANGE), Lori Heise (PATH), Victoria Jennings (IRH/Georgetown), Daniel Kabira (Africa Bureau), Mihira Karra (USAID), Tabitha Keener (USAID), Jim McMahan (INTRAH), Manisha Mehta (EngenderHealth), Diana Prieto (USAID), Julie Pulerwitz (Population Council), Karin Ringheim (PATH), Debbie Rogow (Population Council), Diana Santana (JSI), Diana Santillan (JSI), Jeff Spieler (USAID), Mary Nell Wegner (EngenderHealth), Amy Weissman (Save the Children), Alfred Yassa (JHUCCP).

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Report of the working teams to the committee

Communications Working Team

Mary Nell Wegner, outgoing Chair reported for this team.

New Chair. Jim McMahan agreed to be the next Chair of the Communications Working Team, pending approval from INTRAH.

Proposal: "Dissemination Strategy for State of the Art Lessons on Gender, Men and Reproductive Health". The communications team reviewed the proposal and suggested that the budget include funds for commissioning papers in advance of the State of the Art (SOTA) Conference, which will provide the content for the Implementation Guide, a follow-up to the Orientation Guide, the primary intended output of this conference.

Speakers Series. Lorie Heisi and Mary Ellsberg will be kicking off the Speakers Series today. Plans are to continue to bring experts to speak to the Subcommittee through June 2002.

Research and Evaluation Working Team

Julie Pulerwitz, the new Chair of this working team reported on this team's meeting.

Attendance: Debbie Rogow, Julie Pulerwitz, Karin Ringheim, Amy Weissman, Sam Clark, Meg Greene, Jeff Spieler, Manisha Mehta, Daniel Kabira, Laurette Cucuzza, Paul Feldblum, Erin Anastasi, Anna Benton, Jay Gribble, Tabitha Keener.

Meg Greene, the current coordinator of the Research Group will be stepping down, with Julie Pulerwitz replacing her. Everyone agreed that Meg has done a marvelous job.

The case studies will have final editing by PRB and be published together as one unit. The three case studies are: Salud y Genero; Stepping Stones; Society for Integrated Development of the Himalayas (SIDH) Meg Greene will write the introduction and make the first edits on the drafts. A reduced draft will be available soon and will be sent to the co-chairs for further revision. USAID will review this draft as well. Comments on the draft should be completed by December, before Meg submits it to PRB. The full draft is available to whoever wants to review it as a longer document as long as they do not cite it. It was suggested that there be an executive summary in the beginning. The audience for these case studies is program designers, managers and researchers.

Power in Sexual Relationships monograph is now complete.

Evaluation of the CD-Rom—Dr. Yassa will be using the original evaluation with one additional question. A random sample of those who were sent the CD Rom will receive the evaluation. JHUCCP sought suggestions for possible incentives to get people to participate in the evaluation. A scope of work has been written, but funding issues need to be resolved.

Theme Statements—The gender-based violence and dual protection statements are now on the RHO website. Amy Weissman has been working on the adolescent statement, incorporating various comments and concerns. Meg Greene has concerns that there is not enough of a focus on gender equity. Karin Ringheim and Julie Pulerwitz will review the statement to include more language on social equity and socialization.

There was a question as to whether there has been any feedback regarding the theme statements from the website. Sam will get updates on the numbers of hits the site is receiving. The WHO has received copies of the theme statements.

Partnerships newsletter—Debbie Rogow from the Pop Council is now managing this newsletter, but its fate is in limbo. Its role may change to become an electronic clearinghouse of new documents. The Pop Council may not want it on their web site, because it is not considered a research document. The follow up question as to whether this should be included in the dissemination strategy was raised. There is also interest in having it on the RHO website.

Bellagio Report on Men and Gender Based Violence—Jeff Spieler noted from the report that there is an absence of attention to research on men and gender violence. The field is replete with anecdotal evidence, but not studied well.

RHO website—Karin Ringheim reminded people to send information to the RHO website.

Dominican Republic Positive Deviance Study: The following update was received from Sandy Garcia of the Pop Council: "In brief, we have yet to make our first site visit (these past few months were extremely difficult for coordinating travel, especially due to the Sept. 11 events). At the October EC meetings in NY, I spoke with Vivian Brache once again (as well as Suellen Miller who is doing some work in the DR for her ECC project) and we discussed meeting with Vivian and interested members of her staff in early February. Yes, we're running a little behind, but in the meantime have concentrated our efforts on drafting up instruments (both for the DR and the Mexico site, since the projects are very similar), and Suellen has also sent me a description of her DR project so that we can coordinate efforts better (if it makes sense to do so) and to help us establish more local contacts. I'm sorry I don't have much else to report at this time, but I promise that we'll kick things off very soon in the new year."

Future plans include the possibility of evaluating some of the GBV programs presented at the recent Bellagio meeting. Other initiatives funded by the Subcommittee that are in need evaluation include: the HIM CD ROM (in progress), the "Young Men's Journey" Version of the Safari of Life game that PATH has developed, and Margaret Sanger International's Men and RH teaching tool.

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Workplan discussion and budget update

Debbie Rogow suggested that the Subcommittee might want to help disseminate the Population Council's newsletter *Toward a New Partnership* by posting it on its web site and translating it. Tabitha Keener reported that PATH has expended the funds it was holding for the Subcommittee. IPPF/WHR still has some funds. There are $28,000 remaining unrestricted funds available for the Speakers' Series and consultants. The status of the funds held by JHUCCP available for printing a revised Orientation Guide will be clarified by the end of the day.

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Update on IGWG meeting and M&RH subcommittee proposal endorsements and submissions

Diana Prieto provided an update of the IGWG's TAG meeting of September 25. The TAG is comprised of 19 members: 7 USAID PHN representatives, a representative from each of the Regional Bureaus and the WID Office, and 7 technical experts from outside USAID (5 CA and 2 non-CA). The TAG serves as the strategic planning and advising body of the IGWG and guides the work on the IGWG by providing insights into trends and needs in the field. Specifically, the TAG: 1) recommends priority areas and technical themes for each funding year, 2) reviews proposals and makes recommendations to USAID for funding, and 3) reviews progress and products of funded activities. The TAG identified

four priority areas—young people, GBV, male involvement, and HIV/AIDS—for the IGWG in the coming year. These areas served as the focus in the call for proposals sent out by the IGWG. The deadline for the proposals is tomorrow, November 16. The proposals will be reviewed by the TAG in the next month and a half; notification of whether or not the proposals are recommended for funding is scheduled for mid-January 2002.

"Lessons Learned Forum on Men and RH" proposal

Victoria Jennings summarized the proposal, which will be amended to indicate funds leveraged. Under the restructuring of the IGWG, the Subcommittee is proposing to evolve into a think tank, a generator and disseminator of ideas. This proposal, along with seven others that the Subcommittee endorsed, including the Dissemination Strategy, will be submitted to the IGWG TAG. Jeff Spieler urged that the proposal include adequate compensation for the time co-chairs spend working on the Subcommittee/Forum.

Endorsed proposals

The Subcommittee had expected to endorse three proposals but, in the end, agreed to endorse seven. Ten proposals were not endorsed because they did not fit into the Subcommittee's framework or address its major themes. These proposals can, however, be submitted directly to the IGWG. Mihira Karra clarified the TAG's preference for funding short-term discrete activities. Funds for approved proposals will be obligated in July and must be expended within the proposed time-line.

Transparency

Sam Clark expressed his sincere hope that members of the Subcommittee were clear about the funding process, had enough information and time to submit proposals and urged members to provide feedback about the process. He explained that PATH would be submitting the Lessons Learned Forum proposal because the IGWG requires that grant agreements pass through a co-chair's agency, which must be a cooperating agency (CA). Karin Ringheim addressed the issue of inequality within the Subcommittee due to the fact that some people's work is compensated while others' is not. She cited the example of Meg Greene, outgoing chair of the Monitoring and Evaluation Working Team, employed by an organization that is not a CA. Ringheim also suggested that some organizations received funds for a discreet project under the IGWG that could have been funded under their regular CA agreement.

Management issues

Sam Clark informed members that his term expires in July 2002. Ideally his successor should be male and rules mandate that co-chairs be employed by a CA. Given the restructuring and uncertainty of the future of this subcommittee, Clark indicated that he would be willing to consider extending his term as co-chair if this would be helpful in providing continuity. Jeff Spieler supported this offer.

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IGWG Men and RH Speaker Series presentation on gender-based violence (GBV)—Lori Heise and Mary Ellsberg (PATH)

"Coercion and Abuse: Implications for Health Programs" by Lori Heise

Lori Heise, Senior Program Officer at PATH, began the joint presentation on GBV by discussing the prevalence of abuse worldwide. Lifetime rates of physical abuse by a partner range from 10–50% of women, depending on the country. Rates

of sexual abuse during childhood are estimated at between 11 and 25% of women (with lower rates reported among men). However, these figures tend to be underreported, so actual rates are likely to be higher.

One common type of abuse discussed was forced sex. Studies around the world indicate that "refusing a man sex" is one of the most commonly cited reasons for wife beating. (In addition, an ICRW 15-country study of women's HIV risk found that many women have been forced to have sex or participate in sexual activities against their wishes.) Heise also noted that, in many countries around the world, wife beating is the norm**.**

Addressing the health consequences of abuse, Heise detailed the fatal and non-fatal outcomes resulting from such violence. Fatal outcomes include: homicide; suicide; maternal deaths; and AIDS-related deaths. Non-fatal outcomes include physical and mental suffering, injurious health behaviors, and reproductive health problems, such as: unwanted pregnancy; chronic pain syndrome; injury; depression; alcohol/drug use; STDs/HIV; irritable bowel syndrome; gynecological disorders, etc.

Examining the link between violence and health outcomes, Heise suggested that violence is best conceptualized as a risk factor. For example, women who have experienced abuse generally have reduced physical functioning, increased physical symptoms, worse health, more life-time diagnoses, and higher utilization of health care. Further, the severity of abuse is correlated with the severity of symptoms.

More specifically, the impact of violence and abuse on reproductive health is equally damaging, with consequences including: reduced sexual autonomy, lower contraceptive use, higher parity, earlier age at first intercourse, more risky sexual behavior, unwanted or mistimed pregnancies, adverse pregnancy outcomes, and gynecological problems such as PID, chronic pelvic pain, and vaginal bleeding.

Violence during pregnancy is another serious problem around the world. It is associated with adverse outcomes such as: late entry into prenatal care, increased smoking and substance abuse, vaginal and cervical infections, premature labor, miscarriages/ abortions, bleeding during pregnancy, and low birth weight.

In addition, violence increases one's risk of contracting STIs and HIV. Sexual abuse in childhood is also linked with HIV/ STD risk, as those abused in their youth are more likely to engage in unprotected sex, have multiple sexual partners, and trade sex for money or drugs.

Heise advocated for a "graduated response to violence", including the following: first, do no harm (making sure that RH programs do not "re-victimize" women, compromise their safety, undermine their autonomy, or reinforce male entitlement or violent imagery). Next, integrate issues of gender, coercion, and abuse horizontally into existing RH initiatives (into existing training programs for providers, IEC and BCC programs). Finally, undertake efforts to address coercion/abuse (implement pilot projects that address abuse directly).

Finally, Heise discussed involving men in efforts to prevent and eliminate GBV. Batterer treatment programs were reviewed and evaluated. The need and possibility to break the cycle of violence was underscored, and it was noted that, while men who were abused as children are at higher risk of becoming abusers as adults, the majority of boys experiencing violence as children do not grow into abusers. Selected international and domestic projects were highlighted as examples of successful programming.

"Innovative approaches to monitoring and evaluating violence prevention programs" by Mary Ellsberg

Mary Ellsberg, of PATH, began by describing the challenge of evaluating the impact of GBV interventions. Specifically, how to define success, who defines success, and how success is to be measured.

Ellsberg outlined and discussed four different approaches to measuring impact, including: 1) prevalence and incidence indicators; 2) quantitative indicators of quality of care; 3) participatory assessments; and 4) measuring changing norms.

First, Ellsberg examined measurement by national victimization statistics. She detailed problems with this indicator, including the facts that it is not representative of the population, is not "interpretable", and sets the bar too high.

Regarding population-based data on prevalence of violence, Ellsberg pointed out that they are very sensitive to methodological issues, making it hard to compare between settings. They also involve safety and ethical concerns. Further, it is unrealistic to expect to see a reduction in the prevalence of violence over the short or medium term. While population-based data may not be ideal for program monitoring and evaluation, they are useful in advocacy and program design, in order to understand the magnitude and characteristics of violence, as well as the health burden of violence, and both risk and protective factors.

Another approach, quantitative program level indicators, such as those used by IPPF, involves measuring institutional changes (staff training, physical space, etc.), changes of attitudes of staff (pre/post training), and implementation of screening (% of clients screened and identified as victims of violence). These types of data may be useful in identifying clinics that are not implementing program activities, identifying "pockets of resistance" to the program, and identifying possible "bottlenecks" in the system. However, they do not offer information on how women define success and whether or not intervention programs meet their needs.

Participatory approaches were also examined. By examining examples of IPPF and PAHO programs which used this approach, the following lessons were learned: the approach incorporates the perspectives of all stakeholders and allows for comparisons between groups and countries. Criteria for successful intervention included: providers listening with empathy and women feeling empowered to make their own decisions.

Finally, as an illustration of the approach of measuring shifting norms, a mass media campaign ("Puntos de Encuentro") directed toward men in Nicaragua was evaluated. First, a qualitative study on "non-violent" men was conducted to determine what factors influenced them to reject violence, what they perceived as the benefits of being non-violent, what costs were entailed, and what their expectations for a good relationship were. These data were compared with "average" men from workshops on masculinity. Results revealed that non-violent men perceived benefits to their behavior, such as improved communication with their partners and children. However, they also had different expectations for their relationship, so the benefits they perceived may not be meaningful to other men.

The multi-media campaign involved such activities as television commercials, posters, bumper stickers, pamphlets, caps, bill boards, calendars, methodological guidelines, and trained promoters. To evaluate its impact, surveys of 2,000 men before and after the campaign were conducted (with support from FHI), 660 women were surveyed post-campaign, and focus groups were held among participating organizations. Results of the survey indicated that 60% of men surveyed knew of the campaign and that men who had heard the campaign were more likely to believe that men can avoid violence and to see the damaging effects of violence on women and the community. The campaign also encouraged men to talk about violence; 50% of men who heard a message talked about it with someone, and 88% believed the campaign had made a difference in men's behavior.

In closing, the following lessons learned were highlighted: there is a need for stronger links between research and interventions for program design and monitoring; both qualitative and quantitative methods are useful; GBV intervention programs should strive to develop client-centered indicators for success.

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Discussion on men and GBV: What role for M & RH SC?

Victoria Jennings facilitated this "brainstorming session" in which all M/RH participants, as well as the two guest speakers (Mary Ellsberg and Lori Heise) had the opportunity to offer ideas as to what course of action the M/RH SC might take to actively address the issue of GBV. Ideas/comments expressed included the following:

- Lobby for RFA that focuses on GBV.
- Lobby for including GBV in other projects (by adding evaluation points, for example).
- What impact data do we have?
- Sensitize, educate AID regarding the importance of addressing GBV to reproductive health outcomes.
- Conduct research in other countries to show causal (not just associative) risk of GBV to RH outcomes (i.e. violence as a precursor to early, unwanted pregnancy).
- Develop a conceptual framework on the overlaps between M & RH and men and violence (to this end, the report of the Bellagio conference included recommendations, which are being developed into a proposal for IGWG funding).
- Identify entry points in key regions and countries.
- Identify sites to pre-test English version of 5 workbooks for boys and adolescent males (which include a module on violence) developed by IPPF.
- Bring together master trainers with all their best tools and materials and make one consolidated workbook, to be disseminated to program implementers.
- Inventory of existing programs addressing GBV (CHANGE is already working on this and plans to hold a brown bag on the topic on January 9, 2002.)
- Identify theoretical and intellectual gaps.
- Share what is already known.
- Review existing projects to determine how they can integrate men and GBV (i.e. YouthNet project, others).
- Develop a tool to help AID program and policy managers integrate GBV into programs (Proposal is being submitted to IGWG for funding and will include development of conceptual framework, literature review, measurement methodologies, etc.).
- Guest speaker Lori Heise recommended focusing on changing social norms in the general population.
- Emphasize importance of couple communication as M/RH SC niche (through research, dissemination, etc.).

Other issues raised during the discussion included what should be the role of the M/RH SC? To collect data? To implement programs? Some felt that GBV should be integrated into projects rather than being a separate project. Some cited a need to focus on the "so what?"—demonstrating improved outcomes. Do we have enough definitive data to show the impact of reducing GBV on RH outcomes? Additional resources mentioned included Emily Rothman, who is working on a Ph.D. with WHO on RH, violence, and men. She is conducting phone interviews with programs working with men who are perpetrators of violence. In addition, a study was cited, "Scared in School", about violence and intimidation/coercion in schools.

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Updates regarding selected M/RH and related CA activities/other business

- **CHANGE** (Suzanna Banwell, Anna Benton, Sarah Heaton)—Change is in the process of mapping RH programs worldwide and developing a theoretical framework for follow up.
- **IGWG Gender and HIV/AIDS Task Force Update** (by Mark Austin)—Activities include: a) A rapid assessment of AIDS programs integrating gender (total of 55 interviews), examining program objectives, gender issues addressed, TA, lessons learned, etc. Initial qualitative analysis to begin in December; compilation of preliminary analysis to be presented to TAG members for feedback. Workshops on best practices will subsequently be designed and conducted; b) EngenderHealth is spearheading the development of guidelines for integrating FP and HIV, and is seeking gender activities to contribute to the document.
- **Population Council, NY** (Debbie Rogow)—*Qualite* journal to focus on masculinity. A program to be highlighted will be chosen in January 2002. (Dissemination date TBD.)
- **PATH** (Karen Ringheim)—"Young Men's Journey" board game, adapted from "Safari of Life" includes a new

set of cards which have been tested in the U.S. and overseas. Pretesting will continue domestically and in Kenya. A proposal is being submitted for additional funding to do an evaluation. Dissemination planned for next year.

- **Jill Gay (consultant)**—Jill, in collaboration with Karen Hardee at Futures, is compiling evidence of what works in RH. (Topics include STDs/HIV, safe motherhood, FP; GBV; all aspects of RH; also gathering data on impact of gender and on impact of men). There is a call for resources on impact evaluations re outcomes. Please submit to Jill or Karen.
- **EngenderHealth** (Manisha Mehta)—EngenderHealth is a) Implementing a project on young men's gender roles and socialization and its impact on their and their partners' RH in the Philippines. Includes qualitative, participatory, research as well as quantitative data collection. An intervention will be designed to improve RH of young men and their partners; b) Men and GBV project in South Africa—examining role men can play in supporting their partners' testing for cervical cancer and following treatment regime. Treatment often involves abstinence for 4–6 weeks, which is often a time of GBV. The project works with adult and young men to sensitize them. Educators have already been trained. Quantitative baseline will begin in January 2002. Post-evaluation and 6-month follow on evaluation planned. (Project also includes clinical arm.); c) Men's RH curriculum being tested in Philippines. Qualitative findings indicate changes in attitudes and knowledge. Results included setting up "men's nights" to discuss issues of relevance to men, as well as hiring of male providers. Curriculum will be available in future (date TBD).
- **IGWG Technical Advisory Group (TAG)** (Diana Prieto)—a) The TAG met in September 2001 and identified the priority areas of adolescence, GBV, HIV/AIDS, and male involvement. These themes guided the call for proposals. Recommendations for funding of proposals will be made in mid-January 2002; b) The TAG also plans to do more training within USAID on the IGWG's function and on gender in general; c) a TOT is to be conducted Dec. 18 and 19 to build a cadre of trainers to train their own CAs and be available to train others in the future on gender issues. (This effort is being spearheaded by Mary Kincaid and the Policy Project at Futures); d) TAG plans to publish the indicators paper and the gender perspectives paper in January 2002. Case studies and a manual on designing gender-sensitive training should be released in February.
- **Michele Burger (consultant)**—a) Michele is working with UNFPA to integrate RH services into the armed forces health services in 3 countries in Africa (Botswana, Namibia, and Madagascar) and 3 Latin American countries (Ecuador, Paraguay, and Nicaragua); b) the Orientation Guide will be available by the end of 2001/ early 2002. The M/RH SC needs to clarify the dissemination plan for this document. Suggestions can be sent to Michèle. (A decision was taken to allow for dissemination without prior modeling, but modeling is encouraged.)
- **CEDPA** (Laurette Cucuzza)—CEDPA is developing a project proposal on Skills for Sexuality Education, Negotiation, and Gender Awareness. This OR project, to be conducted in Uganda, is designed for females 10–19 years old. Women (aunts) will be trained in negotiation skills, sexuality, gender, dealing with violence, etc. The women will then pass the information on to their nieces. Outreach will also be conducted to men through faith-based organizations to try to achieve normative change in attitudes toward respecting women and preventing violence. Situation analysis, baseline, and endline analyses will be conducted at the individual, community, and policy levels.
- **JHU/CCP** (Alfred Yassa)—a) The evaluation of HIM CD-ROM is set to proceed; b) completed evaluation of "Together for a Happy Family" campaign in Jordan; in process of writing final report. Results may be presented at a future M/RH meeting.
- **INTRAH** (Jim McMahan)—developed a gender sensitivity self-assessment tool for providers (field-tested in Bangladesh).
- **IPPF** (Judith Helzner)—a) report of March 2001 meeting on "Power in Sexual Relations" available from Population Council; b) M/RH panels conducted at APHA.
- **PATH** (Sam Clark)—a) paper sessions at APHA on M & RH. (Sam sent out summary of presentations and may be able to obtain full presentations); b) shared theme materials from UNAIDS (Men and AIDS, etc.)
- **Population Council, DC** (Julie Pulerwitz)—a) Report on a second gender and power in sexual relations presentation at APHA (conceptual framework developed, Julie's scale for power in sexual relationships used, etc.); b) Judith Helzer pointed out that Julie Pulerwitz received the APHA Population, Family Planning and RH Section Young Professional Award and the group congratulated Julie.

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Next meeting/plus-delta exercise

Sam Clark agreed to follow up with Subcommittee members about their preference for the next meeting. [The next meeting is set for March 12, 2001.]

Plus (to do again next meeting)

- Master stroke—AM working groups—good structure
- Good amount of time for discussion of presentations
- 2 excellent presentations
- PPT worked
- J. Helzner good focus management for discussion.
- Organized
- "Blue" Background Sheet
- "in-house" access to food
- Venue—thanks CEDPA
- Food was good.
- Sam's attention to detail/preparation.
- Finishing on time!

Delta (to change)

- Lose people by the PM inevitable.
- Increase time for discussion by PPT ? working teams.
- Have examples of some of the products we have produced, especially for newcomers.
- Expand on acronyms list

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To do in the interim

Conference calls for working teams to work on tasks that remain. (Co-chairs will conference with working team leaders).