ARROWs For Change

Women's and Gender Perspectives in Health Policies and Programmes

May 1996 Vol 2 No 1
ISSN 1394-4444

Men's Roles and Responsibilities in Reproduction

Since at least the early 1980s, family planning organisations in Asia and the Pacific and globally, have been trying to increase 'male participation' in family planning programmes. Increase in the use of male-related contraceptive methods (e.g. condoms, vasectomy, and withdrawal) which is the main conventional indicator of successful participation, has not gone up significantly in this time despite strong efforts in certain countries such as the campaigns of Mr. Mechai of Thailand, and the educational promotions of Family Planning Associations in Hong Kong and Korea. Why is this? Is it due to unsuitable contraceptive technology, or ineffective programmes which do not reach men (including contraceptive bias of providers), or that men prefer (and women accept) that it is a woman's role to take responsibility for contraception? We do not really know the answers as research on why more men do not use male methods has not been done.

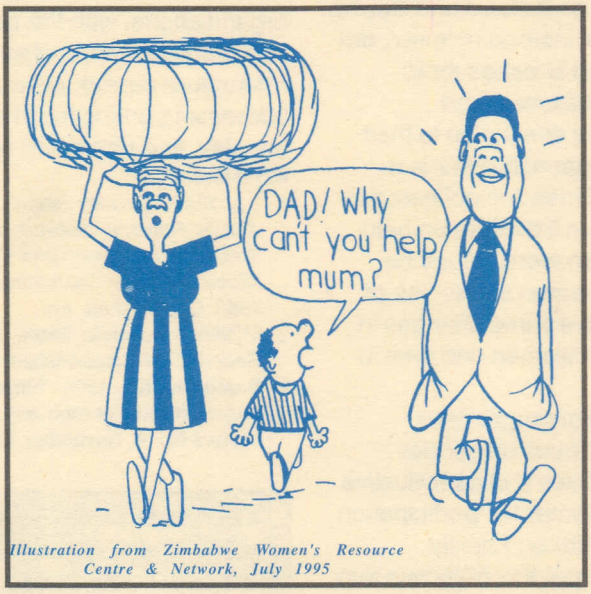

Illustration from Zimbabwe Women's Resource Centre & Network, July 1995

A regional workshop on *Gender, Sexuality and Reproductive Health in Asia and Pacific* held in January 1996 in the Philippines, found that in 12 countries of the region, all of which had low levels of male contraceptive use, little research had yet been done to find out the root of this problem[1]. This fact reflects that there has been little real concern for reaching men and promoting a more gender-balanced use of contraceptives.

Why is Male Contraceptive Use Low?

It does seem unlikely that the problem lies with the technology itself. The condom has effectively been in use globally for 250 years and together with the diaphragm, was one of the main methods in Asia and the Pacific and elsewhere, before the advent of the pill and the IUD in the 1960s. Withdrawal prior to ejaculation is even more established dating back to 2,000 years ago. Vasectomy is a more simple method than sterilisation for women, and since a non-scalpel technique has been devised, there are even less side-effects and inconveniences for men. (See p. 12). Programme-related reasons are probably involved.

Increasing male 'participation' in the use of contraception when first developed as a programme strategy, was aimed at helping to increase the total rates of contraceptive practice. It was thus a demographic and target-oriented objective, and not at all related to men and women's relations and responsibilities. This practical objective, when operationalised, did not address the underlying beliefs and attitudes on the roles of women and men in reproduction which are behind the bias of both the community and service providers towards contraception.

The root of the problem is that it has conventionally been accepted that men's main role in the family is that of the economic provider and women's main role is in reproductive work — child bearing and rearing, housework, and contraception. This division of work responsibility is based on the belief that the sexual or biological differences between men and women mean that they have to play different roles with women being subordinate to men.

It would appear that men are not using male contraceptives more frequently because they do not yet believe that there is a need to, that they have a responsibility to do so, and that women have a right to expect men also to share contraceptive responsibility. Most likely, many women themselves share these same views. In new qualitative research studies, some women have expressed concern on the effects of vasectomy on their partners and appear to have misconceptions even about the condom[2].

Future Directions

The way forward is clearer after the conferences in Cairo and Beijing. The old concept of male participation needs to be recast to focus on reproductive responsibilities towards the long-term goal of recognition of the equal rights and responsibilities of women and men (gender equality) in the family and society as stated in the Beijing Declaration:

> *Equal rights, opportunities and access to resources, equal sharing of responsibilities for the family by men and women, and a harmonious partnership between them are critical to their well-being and that of their families . . .* (No. 15, p. 6)

In addition, the terms 'male participation' and 'male involvement' which have been commonly used to describe men's role in family planning are too narrow conceptually to be useful in this post-Cairo and Beijing era. For a start, the use of 'male' instead of 'men', de-emphasises men's humanity and stresses their biological difference. Then, 'participation' and 'involvement' do not have a right's dimension to their meaning. 'Men's reproductive responsibilities' is a stronger term which implies that men are obligated to carry out certain activities and can therefore be held accountable. Responsibilities can more clearly be linked to rights; in this context women's exercise of their reproductive rights will involve some changes in perceived responsibilities of both women and men in work related to reproduction.

The first step then is a review of programme objectives and the inclusion of a focus on gender equality, reproductive responsibilities and reproductive rights, rather than on male involvement or participation alone. The next challenge to health and family planning organisations is how to put this objective into practice. In education programmes in clinics, the community and schools, men need to be encouraged to take on more responsibility and women need to see that this will benefit them. The information and education process, therefore, has to include discussions of roles and responsibilities of men and women in reproductive work, particularly contraception. Providers need to take a stand on gender responsibilities and communicate this to their clients as does the model Profamilia Family Planning Association in Columbia. This is what is meant by having a gender perspective on contraceptive use. Much more research has to be done to establish, specifically, what are the barriers to men exercising more reproductive responsibility, as perceived by women and by men, as well as operational research on what programme approaches best lead to attitudinal change.

Health and family planning agencies need to be part of a larger societal change towards more equal roles of men and women post-Beijing. Contraceptive use has to be conceptualised as part of reproductive work, along with child care and socialisation, cooking and housework, and family health care. It needs to be recognised that women are still carrying out most of this important, time-consuming, yet unvalued work despite the fact that men with their higher fertility, produce more children than women do in their lifetime. Men have a higher fertility rate than women due to their biological capacity to remain fertile until old age, their higher rate of re-marriage after widowhood or divorce and the incidence of polygamy in some communities[3]. This also implies that men are more sexually active (in terms of frequency of sexual relations) and yet men are known to be reluctant to practice safe sex (including condom use).

It is time that we talked more openly about these concerns within health and family planning organisations, with the people who come to our clinics and programmes, and among ourselves in an effort to restructure reproductive work in a deeper way, thus addressing principles of social justice, gender equality, and rights and responsibilities. **RA**

■End Notes:

1. __. 1996. "Country report", [Papers presented at] *Asia and Pacific Regional Network on Gender, Sexuality and Reproductive Health and Fora on the Teaching of Health Social Science Conference, Cebu, Philippines, January 8-13, 1996.* Unpublished. v.p.
2. **IRRRAG Malaysia Team.** 1995. *Malaysian IRRRAG Report: Draft.* Unpublished. 164p.
3. **Bruce, Judith.** *1994.* "Reproductive choice: the responsibilities of men and women". *Reproductive Health Matters* No. 4, November 1994. pp. 68-70.

ARROWs **For Change** is published three times a year and is a bulletin primarily for Asian-Pacific decision-makers in health, population, and family planning, and women's organisations. It provides:

• Women's and gender perspectives on women and health, particularly reproductive health • A spotlight on innovative policy development and field programmes • Monitoring of country activities post-ICPD, Cairo • A gender analysis of health data and concepts • Resources for action.

It is produced with inputs from organisations in Asia-Pacific and the ARROW Documentation Centre. The Swedish International Development Authority (SIDA) funds the bulletin.

Written contributions are most welcome. Please send them to:

The Editor, Asian-Pacific Resource & Research Centre for Women (ARROW), 2nd Floor, Block F, Anjung Felda, 54000 Kuala Lumpur, Malaysia.
Fax: (603) 2929958 ♦ Tel: (603) 2929913
New e-mail: arrow@po.jaring.my

Printed on recycled paper

Getting Men to be Responsible in Sexual Relations:
The HIV & Heterosexual Men's Project
by Tim Wong

Studies done in Australia on the spread of HIV infection suggest that many heterosexual men and women engage in high risk behaviours which include having multiple sexual partners and not using condoms[1,2]. From a health promotion perspective, the potential for heterosexual transmission of HIV is a real concern, and the promotion of HIV and safe sex issues in the heterosexual community needs to target both men and women.

In 1992, Family Planning New South Wales (FPNSW) conducted a needs assessment of heterosexual men regarding HIV issues. A report titled *Your Little Head Thinking Instead of Your Big Head* details findings from the assessment and the project's activities during this period. At the end of 1993, FPNSW implemented the Heterosexual Men's Project with the objectives of developing: appropriate STDs (including HIV) and safer sex information resources for heterosexual men; and education programmes and resources which enhance communication skills, promote comfort in talking about sex, and provide strategies to promote safer sex practices.

Why Heterosexual Men?

From the assessment, it was found that heterosexual Australian men do not see the relevance of HIV education information in their lives as they consider HIV to be a disease of the 'other' such as homosexuals and drug users. This misguided belief can be attributed to the initial phase of HIV education campaigns which stressed the identity of those who are at risk rather than the behaviour which placed them at risk. Also, previously, there was not any programme responding to heterosexual men's specific needs.

Examining Gender Roles

Research has found that within heterosexual relationships, there appear to be a number of beliefs operating which support the incongruence between knowledge and behaviour. It has been suggested that heterosexual men and women are knowledgeable about the transmission modes of HIV[3] but at the same time, they hold some dangerous beliefs which have obstructed them from taking on HIV and related health messages. These beliefs include:

a. Gender expectations and inequalities. Men are perceived as the initiators and in control of sexual encounters, whereas women are often not given a voice.
b. That heterosexuality is 'natural' and thus cannot, by definition be dangerous.
d. That HIV is more prevalent in 'other' community groups.
e. Heterosexual men can distinguish between 'clean' and 'unclean' women.[2,4]

The first point in particular reflects the gender role expectations which often frame heterosexual relationships in ways that can adversely affect the adoption of safe sex practices. For example, men do not listen to women when women request for safe sex practices. It is, therefore, important that these findings be addressed as part of any sexual health educational or promotional campaign.

Low Condom Use

The remarks that condoms are 'unnatural', 'unromantic', 'spoil spontaneity', 'undermine one's manhood' and so forth were often heard during the assessment survey as reasons for not wanting to use them. The concerns about condoms are related to embarrassment when having to introduce the topic, and to unavailability during sexual encounters. The issue of greater concern is that by using condoms, the men believe that this implies either they or their partner is diseased or promiscuous. By not raising the use of condoms, these dilemmas are avoided and at the same time the opportunity to have sex is preserved. Hence, there is a need now to further promote the use of condoms in a more positive light; that is, by stressing that in wanting to use condoms, men are saying that they want to stay healthy and be responsible.

Reaching Out to Men

Training workshops developed by the project entitled ***Lets Talk about Sex*** and ***Sexual Health for Men*** are designed for health care workers (e.g. nurses, counsellors, educators), and they are aimed to address HIV and sexual health issues by examining the issue of gender and its effect on sexual relations and safer sex negotiation.

Lets Talk about Sex:

This workshop was developed in collaboration with the Women & AIDS Project at FPNSW. The project aims to increase visibility of all women affected by the HIV epidemic and to improve women's access to information services. It is, therefore, most appropriate for the two projects to work together to examine safe sex negotiation between men and women from a conversational style perspective. The misunderstanding that can

happen because of the way men and women have learned to express themselves, can make negotiation difficult and ineffective. Examining the effects of different conversational styles or safer sex negotiation, may provide another educational strategy for health care workers.

Sexual Health for Men:

This workshop examines some of the barriers health care workers encounter when working with men, and some of the issues which discourage men from giving priority to their general and sexual health. It explores the extent to which social conditioning impacts men's perception of their health. The workshop offers an insight to provide health care workers with new strategies when working with men, in particular to address the unrealistic and inappropriate beliefs that men have about sexuality and sexual relations, before effective education can take place.

Resources

A series of resources on safe sex issues and practices, in the context of general sexual health, were recently created after extensive consultation with heterosexual men from a variety of backgrounds. These men agreed that having information on postcards, refrigerator magnets and posters are effective ways of getting health messages to them.

Heterosexual men have stated that they rarely visit their doctors or medical services and so, having health information materials only at these places will not be really effective. In response to this information, the resources are distributed in such venues as retail shops and cinemas.

It is important to recognise that an effective health promotional strategy for heterosexual men involves more than just appropriate and relevant information. Real behavioural change may emerge when issues pertaining to gender roles are acknowledged, re-examined and redefined. Taking the stand that men need to take responsibility for their behaviours, including those relating to sexual activities, is a start.

■End Notes:

1. **Dwyer** et al. 1992. "HIV risk-taking behaviour among heterosexuals". *The Medical Journal of Australia*, Vol. 156. pp. 438-439.
2. **Smith; Van Buydner; Champion**. 1994. *Men's Health Project Report.* Pilbara Public Health Unit West. Australia.
3. **Kippax; Crawford; Waldby**. 1994. *Heterosexuality, Masculinity & HIV AIDS*, Vol. 8, Supp. 1. pp. 315-323
4. **Waldby; Kippax; Crawford.** 1993. "Research note: heterosexual men and 'safe sex' practice". *Sociology of Health & Illness,* Vol. 15, No. 2. pp. 246-257.

■*Contact details: Tim Wong, Project Officer, Family Planning NSW, 328-336 Liverpool Road, Ashfield NSW 2131, AUSTRALIA. Tel: (612) 7166099 ♦ Fax: (612) 7166164*
■*Tim Wong is a psychologist and has a long experience in the area of community welfare. His main interest is in human relations and sexuality.*

Factors Affecting Men's Use of Contraception: China's Experience

Policy makers and researchers are concerned that men's contraceptive use is low in China. Of the 72 per cent of the population that used contraception, only two per cent used condoms, and eight per cent had vasectomy (1988)[1]. This is despite China having a national policy on family planning that advocates both husbands and wives' obligation to practise family planning, and China being the first country to develop the non-scalpel vasectomy technique. Moreover, a contraceptives distribution network has been set up at every administrative level, through which condoms are provided free in sufficient quantity to meet the demand. However, within China itself, there is a clear disparity in contraceptive use between provinces. This article will discuss some of the factors.

Qualitative Study

The context described above prompted the State Family Planning Commission of China to launch qualitative research in 1993 on men's contraceptive use in three provinces which had distinct differences in vasectomy rates. Sichuan Province had the highest vasectomy rate, accounting for 34 per cent of couples using contraceptives (1992). The lowest, Jilin Province, had a rate of below one per cent, while Yunnan Province was chosen because it constituted most of the minority ethnic groups, and its vasectomy prevalence rate was average compared to the other two. For condom use, the prevalence rate was two to three per cent for all three provinces.

Information for the research was collected using focus group discussions and individual interviews. For the focus group discussions, participants included condom users and their wives, vasectomy acceptors within the past five years and their wives, and women using contraceptives and their husbands. For the interviews, policy makers, project managers, technical providers, and religious leaders were included.

Research Findings

During the focus group discussions, the policy makers recounted, *"people think that child bearing is only women's business . . .* [therefore] *family planning*

becomes women's responsibility instead of men's". This view influenced the design of the information, education and communication (IEC) programme. For example, in Yunnan and Jilin provinces, where the men's contraceptive rates were lower than Sichuan, the men said that they rarely received information on family planning because generally, family planning classes were for women only. However, even when the classes were opened to men, they rarely attended because of the fear of being dubbed 'henpecked'.

Vasectomy:

In the Sichuan Province, the government has been actively funding many IEC activities, imparting information on vasectomy as a low risk and safe contraceptive. A network of high quality services for vasectomy has been developed. Family planning centres down to the township level are fully equipped to perform surgery, and are staffed by well-trained service providers who have to pass an examination and obtain a licence before they are allowed to perform the surgery. Prior to the surgery, service providers would talk through the surgical procedure and follow-up care to the clients. The researchers also observed positive attitudes and actions on the part of the senior government officials. For example, policy makers in the province expressed that vasectomy is harmless, simple, economical, and the operation recovery is speedy. Many of them set an example by having vasectomies themselves. The researchers noted that the Sichuan leadership had created a positive psychological environment and a support service network that encouraged the men's acceptance of vasectomy.

Interestingly, the study also revealed that Sichuan women were the major income providers for their households, responsible for field work as well as house chores, and because of this, their husbands were willing to use contraceptives. Meanwhile, in a different working tradition like in Jilin Province, possibly due to the lack of IEC programmes on vasectomy, many participants had misconceptions that female sterilisation was easier to perform, and that vasectomy weakened sexual ability and physical strength. In Jilin, where men do most of the heavy farm labour, these views have definitely affected acceptance for vasectomy.

In the Yunnan Province, vasectomy services were under-developed due to poor accessibility because of mountainous terrain and poor transportation, and also due to the constraining religious beliefs and traditions of the various ethnic groups. For example, during the focus group discussions, a Bai ethnic said that, *"If one takes vasectomy, he will not have any children even in his next life".*

On a brighter note, those men interviewed from the rural areas that have had vasectomy within the last five years, stated that they were highly satisfied with the method. Most said that the operation was brief, caused no pain, and that they were able to return to normal work within a few days. They no longer worried about unintended pregnancies, and vasectomy has not affected their sexual life. Most respondents put a high value on good counselling and interpersonal communications.

Condoms:

Condom use in all three provinces was low. Various reasons were noted, such as the government's focus on long-term contraceptives rather than short-term ones, and problems with use and storage of condoms in rural areas. Many of the participants also reported that using condoms were troublesome, particularly in a crowded house where privacy is lacking. They also indicated that they needed more information on how to use condoms and what to do if the condom breaks. Dissatisfaction that there were not enough choices and variety were expressed. Interestingly too, some of the minority women objected to their husbands using condoms for fear that this meant that their husbands were using them with other women. The participants also agreed on condom use as a desirable means for postponing the conception of their first child, during postpartum, and after the discontinuation of other contraceptives such as the IUD and the oral pill.

Recommendations

Based on these findings, recommendations have been formulated, which included, designing more policies that encourage men's participation in family planning; providing relevant counselling to develop public consciousness on this issue; improving current technique and policy makers' knowledge on vasectomy, as well as providing more information on vasectomy to the public. Also, the quality control of condoms needs to be improved. More importantly, family planning services need to be upgraded, including laying down feasible service regulations to increase client's accesibility.

The researchers pointed out that men's involvement in family planning is not the same as men's use of contraceptives. They also concluded that men's participation in family planning is significant not only in men's use of male contraceptives, but also in supporting their partners' decisions and usage of female methods. **KR**

■Sources:

1. **UNFPA & The Population Council.** 1993. *Family Planning and Population.* New York: The Population Council. p. 42.
2. __. 1995. "Who holds up half of heaven? Male involvement in family planning". *China Population Today* Vol. 12, No. 2, April 1995. pp. 9-11.
3. **Liu Yunrong** [et al.]. 1994. "Male participation in family planning in China: findings from qualitative research [abstract]". Unpublished. 4 p.

Ahead with Cairo and Beijing

Following the progress of Cairo is the recent Beijing Conference on Women. The Beijing Platform for Action (PFA) is built on several other important conferences, including Cairo. It is essential to note that Beijing supports the importance of the agreements reached at Cairo in terms of reproductive health and reproductive rights. In fact, the Beijing PFA has gone a step further in its health section in stating that sexual rights is also an important focus for improving women's health and status.

Some governments are already combining Cairo and Beijing in their policy and programme planning. For example, in Fiji, Dr. Margaret Chung reported that the Department of Women has been developing a strategy to follow up on the Beijing PFA. This undertaking has also provided an opportunity to integrate Cairo's recommendations, and work on both important documents in a unified manner. In recognising the supportive nature of the Cairo and Beijing principles and recommendations, it is therefore appropriate from now on, that this section of ARROW's bulletin is dedicated to monitoring activities related to the implementation of both Cairo and Beijing's recommendations.

Vanuatu

■The Vanuatu government is setting up a National Secretariat to be responsible for the coordination of the Population Activities Programme at its initial stages. The proposed council is to represent people from all sectors including the NGOs, especially those involved in programmes for improving women's reproductive health, youth's well-being and women's councils. Presently, the steering committee is looking into membership representation, the function of a board and its objectives, its structure and location, and the setting up of the secretariat. Among the board's objectives, as stated in the National Development Plans are, to prepare a national Plan of Action that will ensure an equitable distribution of resources for urban and rural population; to coordinate and raise awareness of the important effects and influences of population changes on overall social and economic development; and to put in place an appropriate system for monitoring the demographic characteristics of the population. The board's major task is to deal with matters relating to the Population Activities Programme. However, official approval for all these mechanisms is yet to be endorsed by the National Development Commission under the Prime Minister's Office, and these activities are currently part of the Minister of Population's portfolio.

New Zealand

■The Ministry of Health has initiated policy developments that have led to a strategy to improve the reproductive and sexual health of New Zealanders, especially young people. The major components of this strategy are reducing cost barriers to contraceptive use; reviewing the level of implementation of reproductive and sexual health programmes in New Zealand schools; developing pilot public health programmes to improve the reproductive and sexual health of Pacific Islands people; and investigating ways of reducing the need for recourse to induced abortion.

Amongst the activities carried out by the Ministry of Health for the young people is a production of a booklet entitled *Effective Health Services for Young People: Te Toioro o Toku Whanaketanga* which identifies key features of effective primary health services for young people. The booklet is designed to provide guidance for the regional health authorities and health services providers for this population group. Together with the Young Women's Christian Association of Aotearoa-New Zealand, other health education resources for young people such as the video, *Safer Sex is Choice*, and a booklet for young women called *Sisters*, have been developed.

As many providers of reproductive health services are from the non-governmental sector, the government is making efforts to involve NGOs, such as the Family Planning Association, in the policy development consultations of national reproductive health programmes. In another area of concern, a public discussion document on the prevention of sexually transmitted diseases has also been prepared. The response to this document will assist in the development of policy advice to the Minister of Health.

China

■Family planning services in China, have been strongly required by the State Family Planning Commission to adopt the following principles, also known as the 'Three Prefer':

a. Prefer integrating information, education, and communication (IEC) with all kinds of quality care services so as to help ease clients' difficulties in dealing with administrative procedures in getting access to family planning services.
b. Prefer informed and free choice in choosing suitable

contraceptives rather than recoursing to induced abortion as a contraceptive method.

c. Prefer routine and daily work rather than rushed work.

Family planning providers who are found violating these principles will be penalised according to the seriousness of the case committed. Although the principles of the 'Three Prefer' were established in 1993, the Cairo conference has played a part in adding momentum to push for their implementation.

Almost all of the family planning providers in China are governmental, except for the Family Planning Association of China. To avoid overlap in tasks, family planning providers work at different levels. At the highest level is the State Council, followed by the State Family Planning Commission, the State Health Ministry, and the Chinese Family Planning Association.

Fiji

Since Cairo, the Family Planning Programme in the Ministry of Health has been renamed the Reproductive Health Programme. This, the government official explains, reflects the adoption of a broader agenda prior to Cairo. UNFPA is the major funder of this programme. Recent changes in the programme's activities are the introduction of hormonal injectables and a new campaign to promote vasectomy, both resulting from recent opportunities to train government doctors in the necessary techniques and acquire the necessary equipment. There is also an increased emphasis on education programmes to prevent cervical cancer and teenage pregnancies as cancer of the cervix accounts for 20 per cent of all cancers for both sexes, and it has been estimated that one in every ten births is to a teenaged mother.

The ministry feels that the introduction of the injectables increases the range of choices available for Fiji women. Meanwhile, although vasectomy has long been available in government clinics, accessibility has been much hampered by complicated administrative structures in the ministry. Under the former structure, all vasectomies had to be performed in the main hospitals only, and vasectomy was classified as a non-priority surgical procedure. Under the new Reproductive Health Programme, vasectomy operations are being transferred to some of the clinics, which means that the client's appointment for the operation proceeds much faster than previously.

The Health Promotion Project, was set up recently to address various health concerns, particularly on family planning and reproductive health issues and the promotion of health facilities in Fiji. This project is co-funded by AusAid and the Japanese government.

A further encouraging development is the establishment of a Regional Training and Operational Research Centre in Reproductive Health at the Fiji School of Medicine. Funding for the centre is provided by UNFPA and WHO. The centre is expected to improve the delivery of reproductive health, family planning and sexual health services in Pacific island countries, including Fiji. An appropriate gender emphasis is to be a specific consideration in its operational plans and activities.

National Contributers:

Kathy L. Rarua
Senior Health Economics & Projects Officer, Vanuatu.

Dr. Jonathan Austin
Ministry of Foreign Affairs and Trade, New Zealand.
Report based on the
UNFPA-Monitoring ICPD Questionnaire.

Dr. Margaret Chung
Population and Development Consultant, Fiji.
Report based on the *Fiji Report for ARROW Research Project on Change in Population Policies and Programmes Post-Cairo.*

Dr. Xiaoying Zheng
Institute of Population Research, China.

INVITATION TO CONTRIBUTE

How has your country responded to the Cairo Programme of Action (POA) and the Beijing Platform for Action (PFA)? What activities have been carried out by governments, NGOs and donor agencies? *ARROWs* For Change wants to highlight activities taken up by countries of Asia-Pacific in implementing the POA and the PFA. We welcome contributions from individuals and organisations. Please fax/mail the latest news by 1 August, 1996, to:

The Editor, *ARROWs* For Change
2nd Floor, Block F, Anjung FELDA,
Jalan Maktab, 54000 Kuala Lumpur
MALAYSIA

Tel: (603) 292 9913 ♦ Fax: (603) 292 9958
***New* e-mail: arrow@po.jaring.my**

Bruce, Judith. 1994. "Reproductive choice: the responsibilities of men and women". *Reproductive Health Matters* No. 4, November 1994. pp. 68-70.

The author of this article questions the assumption that fertility reduction can be addressed by altering women's sexual and fertility pattern. She argues that mothers bear the cost of high fertility on a daily basis in a way not experienced by most fathers, while male fertility is potentially higher than female fertility, because many men may (and also do) father children later in their lives than women. In addition, men often have the last say in decisions affecting the couple's reproductive goals and behaviour, particularly when they disagree. However, some governments paradoxically address their pleas for fertility limitation to women only. Another area affecting fertility behaviour is the women's disproportionate use of time and income for their children. If the costs of bearing and rearing children were more equitably distributed, men might have more incentive to control their fertility. Therefore, gender equity at household level in child bearing families is critical. State policies and legislation which seek to equalise responsibilities for children between men and women, and involving both parents in the care of infants and children are much needed.
■ ***Source:*** *RHM, 1 London Bridge Street, London SE1 9SG, England, UK.*

Claassen, Emily J. (ed.). 1995. *New Frontiers in Male Contraception: Mellon Reproductive Biology Centres' Meeting, Durham Hilton Hotel, Durham, North Carolina, April 23-26, 1995.* Research Triangle Park: Family Health International. 28 p.

This publication is a summary of a meeting that looked into selected areas of male contraception and the possibilities each offers for new discoveries. This biennial meeting was attended by scientists from centres in reproductive biology and applied contraceptive development, representatives from other agencies and research centres in developing countries who are interested in similar research, social scientists and women's health advocates. A series of plenary presentations on the major aspects of male reproductive biology and contraception, and the keynote address on "The cost-effectiveness of contraception" served as a foundation for group discussions. Some of the focusses during the meeting were on: testicular function and control of post-testicular function; hormonal methods of male contraception and immuno-contraceptive methods; programmatic issues of contraception; prevalence of male contraception; the acceptability of contraception for men; and women's views of male contraception. Two special interest groups discussed women's perspectives on male contraception. The outcome of each group work is a set of recommendations on priority research and follow-up activities which gives a very useful overview of current issues in the research of male contraception from a biological and social viewpoint.
■ ***Source:*** *Family Health International, P.O.Box 13950 Triangle Park, NC 27709, USA.*

Ministry of Health and Social Affairs Sweden. 1995. *Shared Power / Shared Responsibility: The Government Bill (1993/94:147) on Policy for Equality between Women and Men.* Stockholm: Ministry of Health and Social Affairs. 28 p.

This publication contains facts about the Swedish equality policy. It also gives examples of practical work being undertaken in many organisations and work places throughout the country, to change the structures which contribute to or strengthen the unequal power relationship between the sexes. Different articles focus on relevant parts of the bill within the context of the daily reality of Sweden. With this bill, the government has established time-specific targets for women's representation on the boards of public authorities and governmental committee.

Among others, the government is giving special support to projects aiming at improving the situation of disabled women and increasing the women's influence in various areas of society. A committee has been set up by the government to investigate the differences in women's and men's access to financial resources, and how economic power is distributed between the sexes. Parental leave and parental benefit that is shared equally between parents is another issue that has received attention. The new Equal Opportunities Act has made it compulsory for employers with ten or more staff to draw up a plan each year containing a review of the pay differentials between men and women at work place. The government has also commissioned the Work Environment Fund to allocate financial resources to research and development work on job evaluation and pay differentials from a gender perspective. With this policy, the Swedish government provides tools and methods to change the structures in various areas of society in order to promote equality and counteract the uneven distribution of power between sexes in all policy fields.
■ ***Source:*** *Equality Affairs Division, Ministry of Health and Social Affairs, 10333 Stockholm, Sweden.*

Mundigo, Axel. 1995. *Men's Roles, Sexuality, and Reproductive Health* [from the International Lecture Series on Population Issues]. Chicago: The MacArthur

Foundation. 32 p.

This publication is the third in the *International Lectures Series on Population Issues* that addresses critical issues in population and development globally. In his lecture, Mundigo gives a general reflection on the issues of men's roles, sexuality and reproductive health, and underlines the fact that men and women have very well-defined roles which vary according to their age and are affected by sociocultural contexts. In striving toward gender equality, there must be consideration of the biological and physiological differences between men and women. Sexual health affects men and women differentially, but it is more frequently women who take the initiative in areas such as fertility regulation and reproductive health, perhaps because men's involvement in reproductive health, including contraception, has been largely ignored by service programmes that have traditionally targeted women. There is hardly any research done that throws light into this area, therefore, the discussion in this publication is largely exploratory and is intended to stimulate debate and to raise issues for further study and policy debate. Increasing men's responsibility in decisions and behaviour concerning sexual practices, including a greater participation in family planning, is a key to improving reproductive health and curtailing the spread of sexually transmitted diseases, including HIV/AIDS.

■ ***Source:*** *The MacArthur Foundation, 140 South Dearborn Street, Chicago, Illinois 60603, USA.*

Population Reference Bureau Inc. 1995. *Conveying Concerns: Women Write on Male Participation in the Family.* Washington D.C: Population Reference Bureau. 32 p.

During the past two decades, women's groups and development experts have worked to raise the status of women in society. Now in some places greater attention is being paid to men as well as women. Experts are asking: how can men be more supportive and involved in family life? This book conveys a range of women's perspectives on male participation in the family. In September 1994, the Population Reference Bureau (PRB) brought together senior editors of women's magazines and newspapers from nine different countries at the International Conference on Population and Development (ICPD) in Cairo, to discuss the 'other half' — men. They produced special supplements in their publications that profiled both global and local aspects of men's involvement in the family. Excerpts from these supplements were reprinted in this publication. The first part, "Men and family planning", provides scenarios from various countries of how traditional factors, and inadequate access to services and information, obstruct men's participation. The second section, "Breaking free of conventional gender roles" discusses the societal expectations that define specific roles for men and women around the world which then affect the raising of families. Common threads link the essays, which cut across the cultural and economic boundaries represented by the nationalities of the women who wrote them. One common theme is that many men want to be more involved in family planning and other family issues, but do not act on their wishes. The articles presented in this publication provide a better understanding of both men's and women's perspectives on the family.

■ ***Source:*** *PRB, 1875 Connecticut Avenue, NW, Suite 520, Washington D.C, 20009, USA.*

Reysoo, Fenneke; van der Kwaak, Anke; Huq, Nasreen. 1995. *The Incentive Trap: A Study on Coercion, Reproductive Rights and Women's Autonomy in Bangladesh.* Leiden: Leiden University. 67 p.

Dominant population-controller's discourse uses frightening expressions to emphasise that developing countries have a population problem and for many years, population policies have focussed on the control of numbers, often through coercive methods, and without taking into account the specific reproductive health needs of women. The most effective way to stabilise population growth is to address the issue in a broader context of sexual and reproductive health. This implies the full respect of fundamental rights of men and women to decide for themselves. This research is an attempt to highlight where population policies impinge upon fundamental reproductive rights, especially of women.

Bangladesh, one of the countries with an official National Population Control Programme that includes incentives and disincentives, was chosen for exploratory research. The primary focus of the research was the exploration of the experiences of women and men who use contraceptive methods or who had undergone a sterilisation where incentives were involved. This study has shown that incentives do not really influence people to make use of family planning services or to choose a particular contraceptive method. There is a very distinct difference in the self-determination of contraceptive use between men and women. A woman is highly dependent on the approval of her husband when she wants to regulate her fertility. This situation reflects an essential contradiction with regard to any programme directed at fertility regulation where women are naturally targeted by family planning programmes. Finally, the influence of third parties, other than a

husband, on a woman's contraceptive choice should not be ignored. In-laws, landladies, and family planning workers are all guardians of normative behaviour. It emerged from this study that the exercise of reproductive rights is virtually impossible in a system where payments, awards and punishments are central means of motivation. In a sociocultural situation where women have little decision-making power over their body and their lives, their autonomy is further impinged upon by such an abusive and coercive system.

■ ***Source:*** *VENA, Leiden University, Wassenaarseweg 52, P.O.Box 9555, 2300 RB Leiden, The Netherlands.*

Williams, Suzanne; Seed, Janet; Mwau, Adelina. 1994. *The Oxfam Gender Training Manual.* Oxford: Oxfam. 634 p.

This comprehensive manual on gender issues was developed by gender trainers and writers, together with development practitioners worlwide, as a positive action to promote the full participation and empowerment of women in all sectors of society. This manual is designed for the use of staff of NGOs who have some experience in running workshops or training courses, as well as for experienced gender trainers. It provides practical tools for influencing development programmes and offers an introduction to the basic concepts used in gender analysis and how to apply them to practical work.

The manual begins with a brief summary and key concepts related to 'Gender' and 'Gender and Development' (GAD). A distinctive feature of this manual is that it combines self-awareness work with training in methods of gender analysis. Thus, after discussing "Getting started for the workshop", activities on "Gender awareness" and "Self-awareness for women and men" follow. The next sections move into gender analysis with "Gender roles and needs", followed by "Women in the world", "GAD" and "Gender-sensitive appraisal and planning". Various analytical gender frameworks and case studies are then presented. The following section on "Gender and global issues" is on how to apply analysis and awareness with a gender perspective to key issues like conflict, environmental problems, economic crisis and culture. This global outlook is followed by narrowing the focus on working with those in NGOs at the community level. "Gender and communications" is on images and text to communicate gender-sensitive messages, and "Strategies for change" helps participants to formulate concrete plans using insights and skills learned. The manual concludes with activities for the evaluation of the workshop.

■ ***Source:*** *Oxfam, 274 Banbury Road, Oxford OX2 7DZ, UK.*

ARROW's Publications

ARROW. 1996. *Health Resource Kit. Women-Centred and Gender-Sensitive Experiences: Changing Our Perspectives, Policies and Programmes on Women's Health in Asia and the Pacific.* Kuala Lumpur: ARROW. v.p.

The kit shares the experiences of organisations and individuals in the region who have succeeded in changing perspectives, policies and programmes on women's health to become more focussed on women's needs and more responsive to gender issues. It highlights a variety of efforts in developing a new women's health policy; sensitising policy makers, health practitioners, and family planning associations; and empowering women with information on health. The kit features: pull-out sections containing concise case studies with lessons learned; practical frameworks, guidelines, questionnaires, planning outlines, and lists of resource materials; wall-chart poster on "Framework for change" that contrasts the conventional family planning approach with a women-centred and gender-sensitive one; and descriptions of concepts and terms as used in the region.

■ *Price: US$50.00 plus US$12.00 postal charges. Payment accepted in bank draft only in Malaysian ringgit.*

ARROW. 1994. *Towards Women-Centred Reproductive Health: Information Package No. 1.* Kuala Lumpur: ARROW. v.p.

What are the meanings of reproductive health and reproductive rights? Why are women critical of population and family planning progammes? What kind of reproductive health services do women want? What are the guidelines and models to follow when re-orienting population policies and programmes? These are amongst the questions addressed in this publication. The package comprises of three booklets: "Broadening the concept addressing the needs", "Ideas for action", and "An annotated bibliography".

■ *Price: US$4.00 plus US$2.00 postal charges. Payment accepted in bank draft only in Malaysian ringgit.*

ARROW. 1994. *Reappraising Population Policies and Family Planning Programmes: An Annotated Bibliography.* Kuala Lumpur: ARROW. 101 p.

The first in a series, this publication would be useful for those looking for more materials and information towards reappraising population policies and family planning programmes, particularly in the Asia-Pacific region. It is arranged in three sections of population and development, family planning programmes, and reproductive health and reproductive rights.

■ *Price: US$5.00 plus US$2.00 postal charges. Payment accepted in bank draft only in Malaysian ringgit.*

MEN: SEXUALITY AND RESPONSIBILITIES

Changes in both men's and women's knowledge, attitudes and behaviour are necessary conditions for achieving the harmonious partnership of men and women. Men play a key role in bringing about gender equality since, in most societies, men exercise preponderant power in nearly every sphere of life, ranging from personal decisions regarding the size of families to the policy and programme decisions taken at all levels of Government. It is essential to improve communication between men and women on issues of sexuality and reproductive health, and the understanding of their joint responsibilities, so that men and women are equal partners in public and private life.

UN. 1994. [Paragraph 4.24 Male responsibilities and participation] *International Conference on Population and Development.* p. 30

Within the traditional male sex role, many myths exist about the sexuality of men. The myth that men always want sex, the myth that the men must take charge of and orchestrate sex, the myth that sex requires an erection . . . both men and women should confront the myths of male sexuality. It should also be realised by both sexes that men have several roles as fathers, lovers, husbands, friends . . . men [have a right] to have and show emotions. This not only implies friendly emotions, but also anger and sorrow. In the media, men are often portrayed by negative stereotypes, such as criminals, alcoholics, abusers, violators . . . the media should also regularly portray the positive aspects of men and the role they play in society.

Rix, Bo A. 1995. "Need for focus on men's perspective in family planning". *Planned Parenthood in Europe* Vol. 24, No. 1, March 1995. pp. 17-19.

The kinds of masculinity which young men are now experimenting with contain many features of the traditional male role, patriarchal fatherliness and the much decried 'softy men'. . . . We know that there will be several masculinities in the future, adapted to individuals, groups and arenas. But the masculinity which we have been able to discern shows signs of variability in a certain direction — towards greater personal assumption of responsibility, towards deeper emotional involvement, and towards greater individuality. . . . Thus, the new masculinity is part of a contradictory process: partly a protest against the many demands made by modern society and partly as one aspect of a deeply democratic movement which is concerned with how the sexes can relate to each other, while focussing on their differences. . . . It is interesting to note that this course of events starts in the home, moving outwards into society, and that it is also a result of changes in society.

Frykman, Jonas. 1995. "Space for a man: the transformation of masculinity in 20th century culture". *Men on Men: Eight Swedish Men's Personal Views on Equality, Masculinity and Parenthood.* Stockholm: The Ministry of Health and Social Affairs. pp. 154-175.

Definitions

Male vs Female Contraceptive Methods: Weighing the Health Risks

Country	Contraceptive Use (%): Selected Methods					
	Male Method		Female Method			
	Condoms	Vasectomy	Sterilisation	Pills	IUDs	Injectables
India ('88-'89)	5	--31--		1	2	-NA-
Australia ('86)[a]	4	10	28	24	5	-NA-
Bangladesh ('91)	3	1	9	14	2	3
China ('88)	2	8	28	3	30	<1
Indonesia ('91)	1	1	3	15	13	12
Rep. of Korea ('88)	10	11	37	3	7	-NA-
Viet Nam ('88)	1	<1	3	<1	33	0

The inherent gender bias in current family planning services is being criticised by women's health advocates and other health organisations, especially after Cairo. As illustrated by the data in the table, women are bearing the burden of contraceptive use partly due to this bias. However, if comparison is done amongst the various methods based on health risks and side-effects, contraceptive effectiveness, and procedural convenience, both condoms and vasectomy rank high in all of these categories. For example, for effectiveness against pregnancy, the rate for condoms is 70 to 90 per cent, while for vasectomy, it is over 99 per cent[1].

The two most popular female methods in Asia-Pacific are female sterilisation (tubal ligation) and the pill. Although both are highly effective, the associated health risks are also higher. Tubal ligation has a slight risk of surgical complications such as infection, and anaesthesia-related deaths. Ross, Hong and Huber[2] reported that there were 5.4 deaths per 1,000 tubal ligation procedures, as compared to one per 100,000 vasectomy procedures. Compared to vasectomy, the operation is more complicated and expensive. Therefore, although tubal ligation is over 99 per cent effective[1], it has to be weighed against the possible health complications. The oral pill, with 92-99 per cent effectiveness[1] when taken properly, has possible side-effects such as blood clots, heart attacks, strokes, hypertension, and mood changes. The pill must be taken regularly each day regardless of the frequency of intercourse. Injectables, with 99 per cent effectiveness[1], have been known to cause menstrual irregularity, headaches, depression, nausea, and weight gain. Injectables also need to be administered every one to three months. Meanwhile, possible side-effects and risks associated with IUDs are cramps, bleeding, pelvic inflammatory disease, and infertility, and in rare cases, perforation of the uterus. Also, insertion and removal of IUDs have to be done by a doctor.

It is important to note that the safety of contraceptives is related to the conditions in which they are provided, the conditions in which they are used, and the personal health of the user. Unhygienic conditions in clinics or at home, or past sexually transmitted infections, for example, will contribute to the risks.

Despite the health risks involved with female methods, men are not encouraged enough to use male methods which have less risks, unless this serves the goals of family planning policies of a particular country as in China, or in the global wake of the AIDS pandemic. Vasectomy is a major contraceptive only in a few countries, such as Australia, China, Republic of Korea, and India. This lower rate persists despite the development of the non-scalpel vasectomy technique that makes a very safe procedure even safer, and easier for the client — with little or no bleeding, fewer infections, fewer build ups of blood under the skin (hematoma), and even less operative pain. For example, a study in China reported that the rate of hematoma was 0.08 per cent, or one in every 1,250 vasectomies[3]. The condom is also a very reliable method, with almost no side-effects except in rare cases of rash and irritation to latex. The condom only needs to be used immediately before intercourse, and it requires no follow-up health care. Also, with quality control during manufacturing, and proper storage and application, the chances of condom breakage are very low indeed.

The fundamental message in promoting men's contraceptive use, is the need to operate within the context of equal rights, opportunities and access to resources, and equal sharing of responsibilities for the family by men and women as stated in the Beijing Platform For Action. Motives and incentives for promotion of men's use should not start and stop at meeting a country's demographic goal, or for sexual health reasons only. KR

■References:

1. **Blumenthal; McIntosh.** 1995. *PocketGuide for Family Planning Service Providers.* Baltimore: JHPIEGO Corporation. p. 2
2. **Ross; Hong; Huber.** 1985. *Voluntary Sterilisation: An International Fact Book.* New York: The Association for Vountary Sterilisation.
3. **Huber, D.** 1988. "Advances in voluntary surgical contraception". *Outlook* Vol. 6 No. 1. pp. 2-6.

■Data Sources for Table: **UNFPA and The Population Council.** 1993. *Family Planning and Population: A Compendium of International Statsistics.* New York: The Population Council. pp. 38-54.

[a] **ESCAP.** 1993. *Compendium of Social Development Indicators in the ESCAP Region.* [Bangkok]: United Nations. p. 22.