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THE IMPACT OF MALE SEXUALITY ON WOMEN'S AND CHILDREN'S HEALTH

Abstract

There is a strong rationale to involve men in supportive roles in issues that impact on sexual and reproductive health. There is also an urgent need for men to use sexual and reproductive health services in a much more active manner than has traditionally been the case.

Current data on the impact of disease on morbidity and mortality points to the devastating effect that HIV is having, particularly on young women and children. Similarly sexual violence and coercion are having a profound impact. Men have an obvious responsibility to improve the situation, but it is noted that they are not escaping the impact of the epidemic. Men may suffer less from HIV than women in their corresponding age cohorts, but they inevitably pay for this in the long run. When other causes of death, particularly violence and traffic accidents are taken in account, men have a shorter life expectancy than women.

Current research has emphasised the value of several new areas of innovation, which include participatory forms of men's empowerment, health and gender education, the potential role of circumcision as well as structured engagement with high risk industries such as the transport sector and settings such as prisons. There are numerous international examples of successful men's involvement and also an increasing range of South African case studies of progressive initiatives, some national in scope and others more focused at a district level.

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Introduction

Male sexuality is having a profoundly negative impact on the wellbeing of women and children in predominantly two problem areas which have reached grave proportions; sexually transmitted disease and the effects of sexual and other violence. While men are central to these problems, they are often excluded from the proposed solutions.

Traditionally, sexual and reproductive health (SRH) services including family planning have focused almost exclusively on women. Yet many observers have emphasised that the knowledge, attitudes, behaviours and health of men often play a critical role in determining the reproductive health of women since men often hold decision making power over matters as basic as sexual relations; when or whether to have a child and health seeking behaviour.[1] It may be difficult for women to initiate or enter into dialogue about sex. As a result they may not be able to control and sustain their sexual health[2] or ensure that their sexual relationships are safe.[3]

In much of the literature on gender and development, women are described as hard working and caring with a strong orientation towards community, while men are portrayed as promiscuous[4] and selfish putting their own desires first. Indeed, men in South Africa have almost uniformly been stereotyped as inconsiderate, unreliable, and predisposed to coercion, rape and violence as well as being relatively unable to control their behaviour.[5] While such problems are profound, to continue to emphasise such stereotypes reinforces notions and images of women as disempowered victims with little control over their social and sexual lives. The situation is in fact more complex.[6]

In a recent study[7] on men's health at Hlabisa in KwaZulu-Natal, Montgomery et al. 2006 found that "men are positively involved with their families and households in a wide range of ways. They care for patients and children, financially support immediate and extended family members and are present at home, thereby enabling women to work or support other households."

There is a danger in working from a stereotypical description of 'men' and their desires, motivations and interests.[8] There is enormous variability between individuals, both within societies and between them. The hegemonic view of men as domineering and aggressive may be true for many if not the majority of men, but it is not true for all men at all times. Concepts of masculinity vary enormously between men. There are many men who are gender-sensitive and whose potential for playing a constructive role in bringing about support for women and children has not been adequately realised.

Recognising the need for increased male participation in working towards greater gender equality and improved sexual and reproductive health does not mean that there should be a shift in focus and resources from women to men. But, "if empowering women is to remain the end point … policies for change that involve men must also be grounded in a women-centred and gender-sensitive perspective, not just taking men's perspectives or needs into account".[9]

Gender and Health in South Africa

There are significant gender differences in mortality patterns among South Africans as has been noted in national estimates of burden of disease (measured in deaths by age). Although there are four predominant groupings of disease (a pattern known as the 'quadruple burden of disease')[10] deaths due to sexually transmitted diseases and due to various forms of violence and preventable injury are of particular relevance to understanding the relationship between gender and health in South Africa.

HIV as a predominantly sexually transmitted disease disproportionately affects women at a younger age as an overall cause of death compared to men. The peak incidence of HIV among women in 2000 was in the 30-34 years age group, whereas among men it was in the 35-40 years age group, suggesting that men at least five years older are infecting younger women and / or vice versa.[10] For women below 45 years of age, HIV is overwhelmingly important as an underlying cause of death.[11] Both gender conceptions and biological sexual differences between men and women are linked to this burden of disease distribution.

The second burden of disease which refers to the impact of violence and injury in the form of homicide, road traffic and other 'accidents', disproportionately affects young men, increasing the overall burden of disease in young men compared to women of a corresponding age. For young men below the age of 30 years, injuries are at least as important as or even more important than HIV and AIDS as a cause of death.[10] Again, conceptions of masculinity are central to the distribution of these deaths.

While patterns may not be as apparent for the two remaining burdens of disease (chronic non communicable diseases and infectious diseases) there are also gendered patterns to the distribution of these diseases.[12]

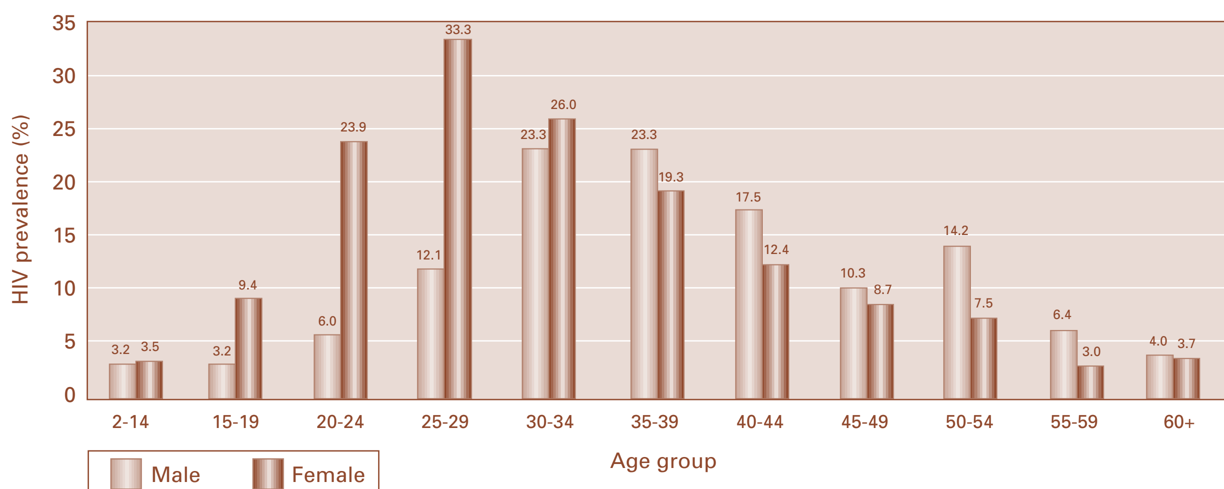
Sexually Transmitted Disease: The Prevalence of HIV in South Africa

Southern Africa remains the global epicentre of the epidemic,[13] particularly around Swaziland.[a] Almost one in three people infected with HIV globally live in this sub region. The situation in SA in regards to HIV, particularly for women and children is dire despite the fact that it is a middle income country. About 43% (860 000) of all children (under-15 years) are living with HIV are in southern Africa, as are approximately 52% (6.8 million) of all women (15 years and older) are living with HIV. An estimated 930 000 adults and children died of AIDS in southern Africa in 2005 – one-third of all AIDS deaths globally. There were 320 000 deaths in South Africa.[11]

Unfortunately despite significant social spending, South Africa's HIV epidemic shows no evidence of a decline. Based on its extensive antenatal clinic surveillance

a Swaziland's national adult HIV prevalence is estimated at 33.4% [21.2%-45.3%]. HIV prevalence among pregnant women attending antenatal clinics rose from 4% in 1992 to 43% in 2004 (Ministry of Health and Social Welfare Swaziland, 2005). Botswana's epidemic is almost equally serious, with national adult HIV prevalence estimated at 24.1% [23.0%-32.0%] in 2005. Lesotho's epidemic is also at very high levels, with an estimated national adult HIV prevalence of 23.2% [21.9%-24.7%]. Zimbabwe's National adult HIV prevalence is estimated at 20.1% [13.3%-27.6%], down from 22.1% [14.6%-30.4%] in 2003. South Africa's national adult prevalence was 18.8% [16.8%-20.7%] of adults (15-49 years) and Mozambique's national adult HIV prevalence was 16.1% [12.5%-20.0%]

Figure 2:
HIV prevalence by age and gender SA 2005



Source: Shisana et al., 2005.[14]

system, as well as national surveys[14] with HIV testing and mortality data from death certification, it seems that the situation is not improving. The Department of Health estimated in 2005 that almost one in three pregnant women attending public antenatal clinics were living with HIV in 2004 and trends over time show a gradual increase in HIV prevalence.[15]

Of the estimated population of 47.4 million, the number of people living with HIV in SA in 2005 was 5.5 million. There were 5.3 million who were adults over the age of 15 of whom 3.1 million were women. Overall the adult 15 to 49 age HIV prevalence rate was 18.8%. There were nearly a quarter of a million (240 000) children 0 to 14 living with HIV.[11]

The gender differences are stark and demonstrate the vulnerability of young women, where there is a very high prevalence reaching a peak in the 25-30 year age group of 33.3% and then declining. Among men, the rise in prevalence is slower than that for women and reaches it peak of 23.3% in the 30-39 age group. The prevalence for men then falls more slowly than for women.

Sexual Violence

SA has one of the highest rape statistics in the world.[16] In 1988, a total of 19 308 cases of rape were reported to the then South African Police Force (SAPF). By 1994, this figure had increased to 42 429 reported cases of rape. In 1996, 50 481 were reported. StatsSA[17] calculated that 55 000 South African women were rape victims in 1997. This figure translates into 134 women raped per 100 000 of the total population in 1997. Since some women were raped more than once, the actual incidence was 143 per 100 000 of the population. It also means that approximately 0.4% of women aged 16 years or more were raped in 1997. Between April 2004 and March 2005, this number again increased to 55 114.[18,19] This culture of sexual violence has several social, political and economic explanations.

Firstly a 'culture of violence' with its roots in apartheid and political struggle has grown and become endemic, dominating South African society over many years, spilling over into sustained and increasing levels of criminal and political brutality. The ongoing struggle and transition has left many men with a sense of powerlessness and perceived emasculation.[20] There are high expectations, massive inequities and significant poverty, all of which exacerbate the sense of impotence that many men feel.[21] Research studies,[2,22,23] suggest that the majority of perpetrators of violence are male and the victims most frequently women and children. This may represent a displacement of aggression which men of all races resort to asserting their power and dominance against the perceived 'weaker' individuals in society. In this context, rape is an assertion of power and aggression in an attempt to reassert the rapist's masculinity.

Secondly, sexual violence is conditioned by culturally-defined male and female roles in society. SA is traditionally a male dominated and patriarchal society, where women are accorded limited power and authority and are frequently exploited or abused, supported by a cultural cosmology that reinforces this. The studies[23] referred to above suggest that rape is more prevalent in societies where societal attitudes are conducive to sexual violence, such as in those that accept and believe in prevailing 'rape myths' such as the belief that men rape because they cannot control their sexual lust, women encourage rape, rapists are strangers and women enjoy being raped. These myths serve to label women as in some way responsible for the rape and to view men's actions as excusable, thereby giving silent consent to their actions. These rape myths also reduce the likelihood of women reporting their rape, for fear of being blamed and stigmatised.

Relationship between Victim and Perpetrator

What is perhaps most counter intuitive about rape is that in 8 out of 10 rape cases, the victim knows the perpetrator.[23] During their lifetime, some 10% of women are victims of rape or attempted rape by a husband or intimate partner.[24] Of people who report sexual violence, 64% of women and 16% of men were raped, physically assaulted, or stalked by an intimate partner.[25] This includes a current or former spouse, cohabitating partner, boyfriend or girlfriend, or date.[24,25]

Perpetration

Most perpetrators of sexual violence are men.[23] Among acts of sexual violence committed against women since the age of 18, 100% of rapes, 92% of physical assaults, and 97% of stalking acts were perpetrated by men.[23] Sexual violence against men are committed mainly by men.[23] Seventy per cent of rapes, 86% of physical assaults, and 65% of stalking acts were perpetrated by men.[23]

Victimisation

Women are more likely to be victims of sexual violence than men; 78% of the victims of rape and sexual assault are women and 22% are men. Sexual violence starts very early in life.[23] More than half of all rapes of women (54%) occur before age 18; 22% of these rapes occur before age 12.[25] For men, 75% of all rapes occur before age 18, and 48% occur before age 12.[23] Women who use drugs and drink heavily are at greater risk for rape while intoxicated.[26]

Sexual Abuse of Young Children

Sexual abuse of young children[27] is usually accompanied by high levels of distress and often by profound disturbance of the child's physical, emotional, social, moral and intellectual development. The effects of abuse are often felt into a person's adulthood and throughout life. Media reports tend to suggest that child sexual abuse is a relatively recent phenomenon. However, child sexual abuse and the rape of babies is not a recent development, is not confined to southern Africa, nor specific to specific cultural communities in the region. Although sexual abuse is important it constitutes a limited proportion of all types of child abuse[28] – the greater proportion for example being neglect associated with deep and long-lasting poverty.

When it comes to sexuality, the defining power of patriarchy and the subordinate position of women and children, means that in spite of laws or norms which forbid sexual acts with children, it is men, with or without the connivance of women, who have the structural and physical power to define sexual relations.[29] Across the world, it is predominantly men who sexually abuse children and southern African men from all backgrounds are no exception. Abuse increases where the cultural norms sanction men exercising power over women and children. The role of the masculine identity in sexual assaults is commonly given less emphasis in research than individual causes in the personality of the child sex abuser. Jewkes[30] clarifies a common misconception regarding virgin-cleansing myths and suggests that most men who perpetrate child sexual abuse probably do not even know their HIV status.

Men tend to see their abusive behaviour as consistent with their culturally conferred male rights. Women may unwittingly collude in this assumption and come to expect their male counterparts to act in ways that are abusive. Many continue to believe the inaccurate assertion that men have difficulty in controlling their sexuality.

The Rationale for Involving Men in Women and Child Health

The rationale for an approach that involves men in women and child health has been widely argued for a variety of reasons.[3,4,31-38]

Entrenched patriarchy, male social dominance, transactional sex and inequality in sexual relations places women at risk of unwanted pregnancy and infection especially as in many instances, it is men who decide to have sex, with whom and whether to use a condom. In addition, men report having more sexual partners than women[b] and both married and single men tend to have multiple partners. It has been found that men do not utilise public health services as much as women do and the almost exclusive use of services by women has, to a great extent, made reproductive health services inhospitable for men. The lack of men's participation in reproductive health services, family planning, antenatal and postnatal consultations means that they do not benefit from any information given by health providers, regarding sexuality or the health of mother and baby, or about their role in it. Research has also shown that men do not seek treatment including

b It is not clear whether the reported behaviour is a case of over-reporting in males or under-reporting in women. Clearly in heterosexual situations each time a man has sex, his female partner does the same, Even given that there is a slightly larger pool of women for each age cohort of men, on average men and women should theoretically have a roughly equivalent number of partners.

antiretroviral drugs at appropriate stages of their HIV infection.[12]

There is thus a strong rationale to involve men in supportive roles in issues that impact on sexual and reproductive health. There is also an urgent need for men to use such sexual and reproductive health services in a much more active manner than has traditionally been the case.

Reproductive Health Services for Men

The issue of accessibility of reproductive health services to men in SA has been a serious logistical and cultural problem and most initiatives, interventions or campaigns on HIV have tended to focus on women and children without exploring the role and agency of men in the disease.

Perceptions of male sexuality are shaped by a wide range of socially embedded gender stereotypes which depict masculinity as being synonymous with having multiple sexual partners and exercising control over intimate partners.

There is thus a strong rationale to involve men in supportive roles in issues that impact on sexual and reproductive health. There is also an urgent need for men to use such sexual and reproductive health services in a much more active manner than has traditionally been the case.

Changing the Attitudes of Men and Boys

Physical assault, rape, and coercive sex have become the norm in male-female relationships in SA making it very difficult for young women to protect themselves against unwanted sexual intercourse, pregnancy, HIV infection, and other sexually transmitted diseases. Violence and coercion is not only a common feature of sexual relationships; studies have found that these are also a feature of everyday life. Physical abuse is perceived as an acceptable and normal method of punishment and as a way of gaining ascendancy and control: thus husbands beat their wives, parents beat their children, and teachers beat their pupils.[39,40]

Presumptions that improving people’s knowledge and awareness will lead inevitably to change in behaviour has not been borne out in practice. A critique[41] of health communications in relation to HIV argued that although health communication scholars have tried to understand how individuals process information and have identified the factors that contribute to appropriate behaviour change, some of these theorists have, implicitly or explicitly, assumed that if individuals were provided with the ‘right’ information they would adopt the recommended behaviour. Some others have endorsed the need to provide behavioural skills along with information so that individuals are able to carry out the desired behaviour. Both approaches, however, are concerned with individual behaviour change. Socio-demographic variables like class, gender, and race have seldom feature in socio-psychological analyses in the HIV context. Limited attention has been paid to the manner in which political, economic, social and gender variables have constrained or enabled individual behaviour related to HIV.

For example, although nearly all people are aware of HIV, an evaluation[37] undertaken in 2003 in SA revealed that only 57% of sexually active males and 48% of females reported using a condom the last time that they had sex. Of these, a far lower percentage (33%) reported that they had always used a condom during the previous 12 months. This seemly irrational behaviour on the part of people exposed to a fatal disease, highlights how difficult it is to bring about sustainable behaviour changes in a population.

The reason for this can be better understood when one considers the complexity of factors that motivate individual behaviour. These include not only the beliefs, attitudes and values of the individuals, but other factors such as self-esteem,[c] self-efficacy,[d] as well as the norms and actions of those around them who influence them (i.e. peers and role models). Models of behaviour change have been investigated to develop frameworks which can reliably bring beneficial change, taking into account the complexity[42] of behavioural change.

c Extent to which a person feels good about themselves.

d How much control a person feels about his / her life.

International Initiatives Focused on Men

There are a variety of novel international and national initiatives that focus on changing the knowledge, attitudes and behaviour of men. However, these initiatives still take place in isolated pockets, and have not yet been integrated in to mainstream sexual and reproductive health programmes.

Behavioural Change

The International Planned Parenthood Federation currently has a number of projects around the world that aim to engage men in efforts to build healthier norms. For example, as a component of an initiative to build sexual and reproductive health capacity in Haiti, support from the foundation enabled the Association pour la Promotion de la Famille Haitienne (PROFAMIL) project to help women and men negotiate sexual decision making and to recognise that both partners decide on condom use together.[43]

With the aim of changing men's gender attitudes and to promote communication between men and women regarding condom use, the Foundation sponsored a project in Kenya[44] that included male-only clinics, motivational exercises to encourage male use of condoms, and various male-targeted information, education and communications approaches, while in Brazil it supports men's discussion groups that encourage men to reformulate certain beliefs about sexuality and the role of men in sexual and reproductive health. Nicaragua has undertaken a National Campaign mobilising men to take a lead in the violence against women and Mexico actively promotes greater male involvement in health promotion and fosters responsible fatherhood. In India an AIDS Prevention Organisation has developed attitudinal behavioural change strategies targeting truck drivers.[45]

In Zambia it has been found that after an intervention to bring about behavioural change among men, many more truck drivers said they had been faithful to their wives or girlfriends after having been educated for several years about the danger of having multiple partners.[46] In 2002 a study of 568 drivers found 0.3% of the group who said they were faithful to their partners. But by early 2006 a similar follow-up study of 1 002 drivers at the same site found that 63.8% reported now being faithful to their wives and girlfriends.

Circumcision

There is currently a great deal of interest in the protective effects of male circumcision in sexually transmitted infections particularly HIV. Although it has long been documented that circumcised males have lower HIV infection rates than uncircumcised males, until recently, no prospective study had specifically tested the efficacy of adult male circumcision in preventing the acquisition of HIV.[47,48]

In 2005, Auvert et al. announced the results of a randomised controlled trial recruiting 3 274 men aged 18 to 24 years in Orange Farm, SA, in an area where almost one in three adults are HIV-positive. The trial found that adult male circumcision reduced the men's risk of contracting HIV during sexual intercourse by over 60% during the 18-month study period.[49] The research suggests that among other possibilities, male circumcision may help to protect against HIV infection by removing cells in the inner foreskin that serve as entry points for the virus.[50]

In July 2005, various United Nations bodies including World Health Organization (WHO) and Joint Programme of United Nations on HIV/AIDS (UNAIDS) Secretariat advised that the SA trial results should be confirmed before male circumcision is broadly promoted as a standard measure within comprehensive HIV prevention programmes.[51] Two efficacy trials for adult male circumcision are underway in Kenya and Uganda, with results anticipated in 2007. The Kenyan trial of 2 776 men uses the same circumcision method as the one tested in SA while the Uganda trial of 5 000 men uses a different circumcision method. Both trials are designed to follow participants over a longer period to assess the duration of any observed benefit and to determine whether the intervention has an effect on overall levels of sexual risk behaviour. A third trial in Uganda is assessing the degree of protection that male circumcision may offer to female partners of HIV-positive men.[11]

Circumcision as a prevention method however, pays no attention to masculinity and the way in which circumcision is located in constructions of masculinity.

The idea that a simple physical procedure can provide complete prevention is problematic. Anecdotal evidence suggests that where circumcision represents the entry into manhood, young males who have been circumcised feel may feel more entitled to sex with women and this in fact is likely to increase instances of dangerous sex, to undermine condom use and to send out the message that unprotected sex is safe if the man is circumcised.

HIV Prevention in the Transport Sector

There have been concerns about the role of the transport sector in creating a conduit for transmission of HIV from high to low prevalence areas where predominantly male truckers are in contact with female sex workers along high volume, long distance transport routes. It is encouraging to note that HIV prevention efforts designed for both of these specific occupational groups (truckers and sex workers) have met with considerable success.

There is now ample evidence that HIV prevention programmes aimed at truck drivers can reduce their frequency of unprotected sex. In Tamil Nadu, for example, research carried out after an HIV prevention programme for truck drivers found the percentage of drivers reporting that they had had commercial sex declined from 14% in 1996 to 2% in 2003. Moreover, the percentage of drivers whose last instance of commercial sex was unprotected fell from 45% to 9% in the same period.[52]

Although long-haul truck drivers are more likely to engage in casual sex due to extended periods of time away from home, short-haul drivers have more access to communities and have been known to withhold goods and food in exchange for sex. This is particularly likely to happen when the goods being delivered are urgently needed, for instance in emergency situations. Opportunities for sexual exploitation and abuse and unprotected sex may increase in such situations and need to be addressed.[53]

Programmes targeting truck drivers are most effective if carried out with the agreement of both employers and employees. In SA, an agreement between representatives of workers and employers has led to the establishment of a network of roadside clinics that provide general health services and HIV prevention interventions.[54] In Malawi, the World Food Programme (WFP) is in partnership with private companies, non-governmental organisations and the government to provide HIV prevention information, condoms, treatment of sexually transmitted infections, voluntary HIV counselling and testing and referrals for HIV treatment to truck drivers and sex workers in two locations in the country.[11] It is not known to what extent these projects deal with issues related to male sexuality and masculinity. Without such an emphasis, it is possible that behavioural change may not be enduring.

Men and Prisons

The prevalence of HIV infection in prisons is almost invariably higher than that in the general population. In SA, estimates put the figure as high as 41% in the general prison system and higher yet in individual prisons.[52] This affects not only prison inmates but increasingly their female partners and children when they are eventually released. The number of sentenced and awaiting trial prisoners in SA has increased from 81 747 in 1995 to 145 706 in 2005 – a 78% increase in roughly one decade – many of whom will, at some stage be released into society.[55]

Male rape in prison is often associated with the construction of manhood within the prison system and the gendered meanings with which sex is imbued in this context.[56] Typical in prison subcultures, is the notion of 'manhood' as being reliant on the sexual penetration of others. Through the act of rape, the attacker seeks to validate his male dominance and superiority over other inmates and to divest the victim of his masculinity. It has been suggested that one potential response to the experience of having been a victim of rape in prison, is an intensification of violence on the part of the victim when he is released from jail. Outside prison it is women who are overwhelmingly on the receiving end of these sets of relations with men making the decisions. In addition, both violent or coercive and non-coercive sexual experiences in prison may impact on the ability of prison inmates to re-integrate into society once released from prison. Experience in various countries has shown that evidence-based HIV prevention programming is effective in prisons.[13]

South African Initiatives That Work With Men

In general, organisations which have been established to strive for gender justice[57] by working with men are relatively new. Among the first was the White Ribbon campaign, an organisation founded in Canada in 1989. It now has a presence in southern Africa.[70]

In a recent review of men's gender transformation and establishment of men's movements in South Africa,[5] Morrell argues that although steps towards developing policy in terms of gender has been striking, less progress is visible on the ground. Since the demise of apartheid in 1994 and the adoption of a progressive constitution which forbids discrimination on various grounds including gender and sexual orientation, several men's initiatives have emerged, some focused on exclusively protecting men themselves, while other include the protection of women, children and other vulnerable groups.

There has been an increase in the number of local organisations that have been established to work the area of gender equity. Many of these have followed the pioneering work of Agisanang Domestic Abuse Prevention and Training (ADAPT)[59] – an agency focused on training and the prevention of domestic violence. The 5 in 6 project operating in Cape Town since 1993 provided workshops to train men on domestic violence and violence against women in general. Other organisations have worked to encourage men to be good fathers and husbands and responsible citizens, for example, the work of the South African Men's Forum and the Gender Education and Training Network (Getnet).[60]

In other government and non-government arenas, working with men and masculinity is now well recognised. For example, the Commission for Gender Equality (CGE) has created a focus on men while trade unions continue to explore issues affecting men, including paternity leave.[61] Many organisations have worked with youth and boys in the context of HIV infections. Shosholoza for example,[62] is an HIV and AIDS project targeting men in soccer structures in KwaZulu-Natal. This is an effort to mobilise men to recognise the threat of HIV in their lives and to take responsibility for prevention and care efforts. Another is AmandlaMadoda, a men's movement in the Umkhanyakude District of KwaZulu-Natal that works to develop a local brand of 'protective masculinity' where men take responsibility to improve their partners' and their own health.

Men who are living with HIV are clearly being forced to confront normative notions of masculinity and male stereotypes and reassess the way they relate to women.[18] They are beginning to realise that their behaviour makes them more vulnerable to HIV and illness. Like women, they are burdened by non-disclosure and realise that communication with their partners is the only solution. They are under pressure to negotiate condom use and are compelled to confront their health problems and seek medical treatment. Men are also re-evaluating intimidating and aggressive behaviour as they witness the consequences of lack of disclosure by their partners.

A few examples of projects that are positively working with men are considered below.

Men in Maternity Care

A research study conducted by the Reproductive Health Research Unit and the Population Council and the KwaZulu-Natal Department of Health[63] to incorporate men in their partners' maternity care, in order to improve couples' reproductive health and pregnancy outcomes was undertaken in KwaZulu-Natal. This intervention showed that it was indeed acceptable and feasible to involve men in the reproductive health care of their partners. Both men and women were interested in men's involvement during maternity care. However, there remain a number of health service delivery challenges that need to be addressed within the South African context before maternity services become more male friendly.

Prior to the initiative, the majority of men in SA had not usually been involved in the reproductive health care of their partners, particularly in African communities. They did not normally accompany their partners to family planning or antenatal care, and were mostly absent during labour and delivery.

Men as Partners

EngenderHealth has been working in SA to improve reproductive health services, prevent sexually transmitted infections (STIs), including HIV and to transform attitudes and behaviours surrounding gender-based violence.[64,65] Their Men As Partners (MAP) project uses diverse strategies including the arts to educate and mobilise local communities. The MAP project is built on the premise that men can, and often do, play a critical role in promoting gender equity, preventing violence, and fostering constructive involvement in reproductive health.

In association with the Planned Parenthood Association of South Africa (PPASA) the project was expanded and strategic partnerships with community based organisations that mobilise men to transform their attitudes and behaviours concerning HIV and violence against women in different parts of the country were developed. The main activities of this project were training of youth and organisations dealing with sexuality issues in gender, as well as the development of relevant training materials.[66]

Their initial research on men's attitudes and practices in SA lead them to believe that addressing gender issues and violence against women was critical to improving both men's and women's reproductive health. Of the more than 2 000 men surveyed, 58% had never used a condom and 35% had previously had an STI. With regard to gender relations and violence, 22% of men approved of a man's striking his partner, while more than half blamed women for provoking rape by the way they dressed or by walking alone after dark.[67]

Based on these results, EngenderHealth and PPASA then developed a training manual[45] for PPASA educators to conduct workshops with groups of men and women. The activities in the manual used experiential learning strategies to help participants gain a better understanding of gender roles, gender equity, and healthy relationships. The manual also highlighted the effect of gender issues on reproductive health, sexual and domestic violence, and HIV.

The Fatherhood Project

The Fatherhood Project, undertaken by the Human Science Research Council (HSRC) aimed to promote the involvement of men in the caring and raising of children. The project focused on presenting alternative models of masculinity and sought the involvement of policy makers and other role players through advocacy messages. The project targets included shifting the discourse and social norms about fatherhood and promoting 'positive male identities'.[45]

Men in Partnership Against AIDS

'Men in partnership against AIDS' (MIPAA)[67] is an initiative of the Government's AIDS Action Plan of SA which commenced in 2002 with a Men's Imbizo. The purpose of the Imbizo was to mobilise men to take up a challenge of becoming active participants against AIDS, to sensitise men to take greater responsibility for their own health and that of their partners, and to encourage networking. The Imbizo culminated in the establishment of MIPAA with branches in all provinces. However, MIPAA activities do not deal in any depth with issues of masculinity and have not as yet been evaluated.

Male Sexuality and Reproductive Health Project

Health Systems Trust (HST) has been involved in a Male Sexuality & Reproductive Health Project (MSRHP) to sensitise and encourage men to take a lead in the fight against HIV so as to protect themselves, women and children. Undertaken in one district in each of three provinces (KwaZulu-Natal, Mpumalanga and the North West Province), the purpose of the project was to mobilise and encourage the growth of a social support movement around HIV by promoting male involvement in Sexual and Reproductive Health, including HIV.[68]

While the primary target were all men in the selected communities, the secondary target were men in leadership positions including traditional leaders, Local Government, Councillors / Executives, etc.

Key findings of formative research[70] carried out indicated that while men were aware of HIV there seems

to be little understanding of how HIV infection results in disease. The research also found that men perceive HIV and other reproductive issues to be the domain of women and reported a reluctance to use health services. For an example, a number of men indicated that they could only go for Voluntary Counselling and Testing (VCT) to a health facility where services are provided by men.

Interventions have included workshops and campaigns to promote ongoing dialogue amongst males on SRH, STIs and HIV using a participatory approach, the establishment of peer support groups for men, youth and parents, the distribution of HIV, gender and SRH educational material, convening Imbizos on HIV and SRH, targeting males in leadership positions and capacity building and mentoring and support of CBOs and volunteers.

Conclusion

- Social conceptions of masculinity are having a profound impact on sexually transmitted disease and sexual violence, which demand urgent attention.
- Men's active involvement in all aspects of sexual and reproductive health programmes and other innovative projects that work with men are essential not only to protect their own health but to protect that of women and children;
- Gender stereotypes of men as domineering and oppressive towards women and children needs to be reviewed to take into account that there are many men who adopt a protective attitude and whose active engagement is important in the struggle to emancipate women and improve health for all;
- The nature of the HIV and sexual violence epidemics have dramatised the importance of the active engagement of men in preventive and therapeutic efforts. Without such support, the efforts of African women to protect themselves and their children may come to naught;
- There are numerous encouraging initiatives, both international and South African, that can provide models for programmes that engage with men, whether in encouraging participation in sexual and reproductive health services, preventive efforts, gender-sensitivity or more general economically empowering men to provide a supportive environment for their partners and families.

Acknowledgements

The authors would like to extend their appreciation to Robert Morrell, Sithandiwe Nyawose, Petrida Ijumba and Ashnie Padarath for their insightful comments and suggestions for additional references which have greatly contributed to the article.

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