Men, Masculinities and Family Planning in Africa Conference

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Conference notes by Paula Tavrow, PhD (UCLA)

Panel 1 : Constructions of Masculinities among African Youth

This panel looked at masculinity from the youth's perspective and how it is negotiated.

Amber Reed noted that circumcision schools in South Africa have an important effect on how boys become men, and may be reinforcing the notion that "virility" is equated with sleeping with many women. She pointed to the contradictory messages boys receive, and that they tend to lean toward the messages conveyed at circumcision schools. However, she found that a "digital story" project in rural communities--in which youths had opportunities to show gender equality--could help to achieve some fluidity in gender roles, particularly with some outside assistance.

Susan Ajok discussed the Straight Talk program in Uganda to promote safer sexuality and comprehensive factual information for youths. Its newspaper was launched in 1993. Nine million papers are now printed every year (in 5 languages), along with weekly radio shows in 17 languages. She said that it is important to address youth's environment (teachers and parents) to achieve better outcomes. Boys need to engage in "conversations," rather than to be fed messages. And they need support for "affirmative masculinity" that doesn't disparage girls.

Warrick Moses noted that South African hip hop music, which is a staple for youths, can sometimes "flip the script" and portray gender roles in less rigid ways. Unfortunately, musicians can be motivated to exaggerate negative black stereotypes to meet white market demand. Just as the lyrics of music can be gendered, so can instrumentation subtly perpetuate the subordination of women (with a piano connoting female voices, and drums/bass as male ones).

Damola Osinulu discussed Nigerian Pentecostal beliefs about "spirit" women and men, who can sap people's fertility and steal their genitals. He posited that the "Mountain of Fire and Miracles," a Pentecostal holy ground, can seem to have special powers to influence men's masculinity and women's safe delivery.

Panel 2: Masculinities, Human Rights and Sexualities

This panel addressed how masculinities of straight and gay men can be influenced by human rights law, non-government organizations, and new social media.

Lara Stemple noted that studies show that men with regressive masculinity norms suffer worse health. She challenged the "instrumentalist" approach in international human rights law, which only includes boys and men in the context of their responsibility to change in order to increase women's access to information and services. She argued that it is wrong to consider men as a monolithic perpetrator class, rather than as people who have rights not to be assaulted, etc.

Olajumoke Yacob-Haliso noted that rape is the highest reported crime in Liberia, and affects mostly women but also men. Yet she didn't find any NGOs with programs for men, which may be contributing to "invisibility" of men's experience of violence. She also noted that NGOs seem to be reassigning women to home spheres, even though they may have been soldiers during the war. Meanwhile, men are considered "cowards" and unmasculine if they didn't fight and kill.

Donald Donham discussed how globalization and social media can provide opportunities for non-normative sexualities (such as male-male sex) in Africa. In Accra, Ghana, he found that urban life and relative anonymity can allow male-male subcultures. Specifically, the rise of internet cafés and internet dating websites can allow Ghanaian gay men to exercise their sexual imagination confidentially. They seem predominantly interested in finding older European male lovers to give them access to world capitalism.

Keynote Address (1) by Professor Mark Hunter on: "The Concurrent Partnerships Debate: The Contribution of Historical-Ethnography"

Mark Hunter argued that the changing political economy of intimacy, rather than cultural or industrialization narratives, may be the most useful explanation for the AIDS epidemic in South Africa. He discussed how court records reveal that the "double standard" in sexuality (i.e., that only men were permitted multiple partners) did not exist before the 20th century. However, by the early 20th century, pressure started to be placed on women to have only one partner. The rise of male wage labor (and brideprice or *lobola*, rather than "gifts"), the restrictions imposed by Christianity, and the push for more penetrative sex all contributed to this double standard. Men could be playboys (*isoka*) when young, but had to marry to become a man. A big shift occurred in the 1970s and 80s. There was a rise in chronic unemployment for young people (and hence greater social inequalities) that reduced men's ability to pay *lobola* and marry. Women became more mobile and flocked into urban areas, especially informal settlements, looking for work. This contributed to heightened gender tensions because women felt the need for multiple boyfriends: "one for food, one for money, one for rent." Money exchanges for sex have become common, as well as paying a fine for getting a woman pregnant (in lieu of the more costly *lobola*). Informal settlements in South Africa have twice the rate of HIV, but aren't getting vital testing and other services because they are not recognized by the state.

Panel 3: Multiple Partners, Relationship Dynamics and Masculinities

This panel examined how relationships and contextual factors can influence masculinities and extramarital liaisons.

Ashley Fox, in her examination of survey data from 16 African countries, found that wealthier men and women seem to have higher rates of HIV, not the poorer populations as is commonly held. She discovered that wealth correlates with more extra-marital partners, but is inversely

correlated with polygamy. Hence she believes that informal concurrency among wealthier individuals who can provide gifts or payments to additional lovers (not formal concurrency through polygamy) may be a driver of the HIV epidemic.

Elizabeth Montgomery reported that women in Zimbabwe communicate their "love" to men by doing their cooking, cleaning, and having sex. Yet women often say that they have to be careful to "keep cool and not put on trousers" (i.e., be too assertive) because men act like "children." When it comes to female-initiated HIV prevention methods like gels, those women who disclosed to men and got their approval were better able to be consistent users. Only 15% used the gels secretly. Yet programmatic efforts to ensure male involvement were generally very limited.

Rachel Snow sought to use DHS data to examine the correlates of high fertility aspirations of Ugandan men, who consider 4.6 children to be ideal. She found that the gender questions in the DHS are pretty weak, and do not adequately encompass masculinities. The data did suggest that men's attitudes about their rights to beat their wives (which were highest among younger men) were linked to a somewhat higher ideal family size, but this was not the case with other male attitudes. However, when more educated women lived in the household, ideal family size was lower.

Rob Stevenson analyzed whether Western constructs of power and equity were correlated with contraceptive use in Ethiopia and Kenya. He posited that inequitable relationships (e.g., when men have comparatively more power) may lead to negative sexual and reproductive health outcomes. In Kenya and Ethiopia, he found that high scores on equity and power generally seemed linked to more contraceptive use, which indicates potential threshold effects. Locally developed constructs of equity and power are needed.

Panel 4: Innovations in Family Planning Service Delivery in Africa

This panel focused on some promising new developments in family planning services in Africa.

Philip Adongo described the Navrongo project in rural N. Ghana, which contributed to improved health and family planning use in the region. The three main strategies were to: mobilize the health sector (by giving motorcycles to nurses), mobilize social institutions, and mobilize formal political structures (to build houses for nurses). The emphasis was on communicating to men certain positive aspects of family planning: e.g., that men could have sex with wives when child was an infant, that women could have more time income generation. To foster dialogue and positive behavior change, early innovators met with men who beat their wives for using contraception. The investment of local communities in making health improvments was also critical for success.

Joshua Davis discussed a project to encourage vasectomies in Rwanda. African doctors are not routinely trained to provide vasectomies because of the dearth of clients. However, training doctors, making Rwandan men aware of this option and providing basic information led to a

significant rise in vasectomies. Analysis indicated that vasectomy users were on average 45 years old, with 6 children, farmers and 11% were HIV+. They did not differ significantly from Rwandan men in DHS surveys, which indicates that they were not exceptional.

Alice Cartwright described a research project in Ethiopia that sought to compare the effectiveness of Health Extension Workers (government paid employees) with Community-Based Rural Health Aides (CBRHAs, who are not government employees) in providing Depo-Provera injections to women at the community level. Generally, CBRHAs (of whom 40% are male) can only distribute condoms and pills. The project showed that clients strongly preferred getting injections at home (84%). The discontinuation rate was only 2% of those who received injectables from CBRHAs, versus 12% from Health Extension Workers.

Keynote Address (2) by Professor Caroline Bledsoe on: "Contraceptive Relativities and the Divided Man"

Caroline Bledsoe noted that people don't operate autonomously. Instead, they have all sorts of obligations and relativities. In the West, a huge emphasis is placed on chronological age in discussing women's fertility (and using IVF to "buy years on the biological clock"). But in Africa, Bledsoe's anthropological studies indicate that women's own health (and the need to recuperate from difficult pregnancies and/or births) and the health of the last child may be a more appropriate way to consider fertility. In Gambia, women post-partum know they have a "danger period" when their menses have returned, but they don't yet want to wean the child. Women are concerned that they can "wear out" fast if they have too many closely-spaced pregnancies. They consider pregnancies as "bodily expenditures on behalf of a man" and may seek to delay childbearing if they are not being well supported by a man. Both men and women calculate how much "muscle loss" (in the form of pregnancies, abortions, live births, hard deliveries) a woman has endured for the man. Women who have had more pregnancies than a co-wife feel more "tied" to a man. Rather than seek a quick replacement pregnancy, women who experience a miscarriage or stillbirth are more likely to use contraception for a while to permit their bodies to recover.

Panel 5: HIV, Fertility Desires, and Family Planning (FP)

This panel considered fertility attitudes and behaviors of HIV+ people in Africa.

Rachel Steinfeld noted that 84-90% of Ugandans and South Africans on ART said their current pregnancy was undesired. However, this may be related to the common belief that a child born to an HIV+ woman will automatically be HIV+. In interviews with Kenyan men, she found that HIV+ men who wanted more children were concerned about the survival of the current child, believed that a child can help his/her parents, and saw their FP options as limited or were fearful of FP side effects. Men seemed to like FP talks at clinics and asked more questions than women.

Sara Newmann reported that men in Kenya influence women's FP use and choices. Their disapproval can lead to secretive FP use by women and heavy reliance on injectables. But irregular bleeding can make secret use difficult, thus leading women to have more pregnancies than desired. Also, in a bad marriage where people despise each other (possibly because of HIV transmission), discussion of contraception may not occur. Men are likely to think that women should have "all the children in her womb." HIV+ men seem to be less bothered by the loss of lineage that can arise from lack of sons, and also to be more willing to restrict births due to poverty. Politicians in Nyanza province are encouraging Luos to have more children so that they will have more political clout.

Anne Moore found that HIV+ couples in Nigeria and Zambia were not that different than HIV- people in their fertility desires, but did have a higher unmet need for contraception. HIV+ men and women were both motivated to have children to reach a desired family size and to lead a normal life. Men were more motivated than women to "leave something/someone behind." Very few were motivated by son preference, desire to replace a child, or other family members' views. Like HIV- couples, HIV+ couples' main reasons not to use FP were fears of side effects and infrequent sex. Provider bias can inhibit HIV+ women from getting prenatal care.

Megan Kavanaugh noted that research from South Africa and Tanzania showed that HIV+ women can be pressured to abort. Individuals weigh the risk of having an HIV+ child against the risk of an unsafe abortion. In Zambia, she found that women who felt themselves to be at some risk of HIV were more likely to have had an abortion. In general, Zambians were very antagonistic to abortion, with only 6-14% supporting a woman's choice of an abortion. This went up only slightly if they knew the woman was HIV+. Interestingly, Zambians who perceived themselves to have no risk for HIV were the most supportive of abortion.

Keynote Address (3) by Dr. Isaiah Ndong on: "Men and Family Planning in Africa: What works? What next?"

Isaiah Ndong noted that men in Africa believe that they have to fulfill many roles: protector, decision-maker, leader, provider and problem-solver. However, many do not have the skills to do this. Unfortunately, men can dominate women in key areas of reproductive health. For example, in a study in Kenya it was found that only 42% of women, compared with 80% of men, would like men to be present during an FP consultation. This is because there is a tendency for men during the counseling session to choose for women the FP method to be used. In general, there is very little knowledge about vasectomy (only 32% of men and 20% of women), which may partly explain why vasectomy use worldwide has stayed flat since 1982, but female sterilization has increased significantly. Also, there has been a FP programming bias against male involvement: men are not included in calculations of unmet need; FP is located in areas where women are served and men are not allowed; most FP providers are women; few options are available for men. EngenderHealth advocates that men be "clients, supportive partners and agents of change." It is important to identify and support providers

who are champions of male "shared and cooperative decision-making", and to recognize that both women and men can reinforce rigid gender norms. More research is needed to better understand service models that would work for men and to give them more options.

Panel 6: Contraceptive Behaviors and Power Dynamics

This last panel examined how power (or the lack thereof) can influence male-female relationships and use of contraception.

Jeremiah Chikovore discussed how historical developments in Zimbabwe can affect current male-female power dynamics. Under colonialism, women were disempowered, families were separated, and male emasculation in the workplace began because of low wages. Migrant workers worried about their wives' sexuality in their absence. Subsequently, for the contemporary man, unemployment has wrought a chronic sense of inadequacy, which can lead to violence and self-destructive behavior. To migrant husbands, abortions by their wives are signs of infidelity. Men get angry about premarital pregnancies but also about secretive FP use. They feel that they are losing control both at home and at the workplace.

Adel Takruri examined the role of men in contraceptive use in Menia, Egypt. He found that men were influenced by perceived norms: if they thought most people use FP, they were more likely to use it themselves. However, if the staff talked about FP side effects to men, their use declined. About 14% of couples had discordant fertility desires, with ¾ of men in these situations wanting more children than their wives. Women who defied their husbands' desires and used FP were more likely to be younger, to have fewer children and more schooling.

Susan Igras found in Mali that there was a low use of health services in general, and family planning in particular. As a result, mobile outreach was important. She noted that there were still considerable misconceptions about FP. Malian men were concerned that FP promotion represented white dominance over African men and was a money-maker for whites. They also believed that FP reduces pleasure, contributes to increases in prostitution and adultery in society, can cause sterility, and encourages secretive use by women. Programs to engage couples in family planning discussions are much needed.