Involving Men in Reproductive Health and Family Planning Services: Germane experience from international programs

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Advancing Men’s Reproductive Health in the United States: Current Status and Future Directions Meeting

CDC / Atlanta September 13, 2010
Wide, Consistent & Longstanding Recognition of Need to Involve Men to Improve RH & Gender Equality

- ICPD Platform of Action, Cairo (1994)
- Special Session of General Assembly on HIV/AIDS (2001)
Successful RH Service Programs Need: Systems thinking & holistic programming: “A chain is only as strong as its weakest link”

Increased Access, Quality and Use

Supply

- Increased availability

Demand

- Increased knowledge + acceptability

Meeting Clients’ Reproductive Intentions

Enabling Environment

- Improved policy + program environment
  - Leadership and champions fostered
  - Supportive and evidence-based policies promoted
  - Human and financial resources allocated

Fundamentals of Care

- Service sites readied
- Staff performance improved
- Training, supervision, referral increased
- Logistics systems strengthened

Data for Decision Making

- Accurate information disseminated
- Image of services enhanced
- Communities engaged and supportive of FP

Gender Equity

Stakeholder Participation
Many Barriers to FP/RH Service Access: “The Brick Wall”

Barriers to effective family planning services:
- Physical
- Medical
- Location
- Cost
- Knowledge
- Inappropriate eligibility criteria
- Process
- Gender
- Regulatory
- Socio-cultural norms
- Time
- Legal
- Poor CPI
- Provider bias

Outcomes when barriers are overcome:
- Access to services
- Quality of services
- Contraceptive choice and use
Domains of Male Involvement in International Family Planning and Reproductive Health Programs

- Men as Clients
- Men as Supportive Partners
- Men as Agents of Change

**RH Technical/Programmatic Areas**
- FP
- Safe motherhood
- HIV/AIDS
- Gender
- Preventing violence against women

**Modes and types of assistance**
- Program planning and evaluation
- Training / information transfer / “best practices”
- Medical equipment & supplies
- Demand creation / behavior change comm.
- Advocacy (resources, improved policies)
- Direct service provision
Men encouraged to use RH services to lessen burden of RH complications for their partners and to improve their own health.
## Worldwide Use of Vasectomy

**Estimated Use Among Women of Reproductive Age**

<table>
<thead>
<tr>
<th>REGION</th>
<th>% of MWRA using</th>
<th>Number of users (in millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Africa</td>
<td>0.1</td>
<td>0.1</td>
</tr>
<tr>
<td>Asia</td>
<td>3.7</td>
<td>27.2</td>
</tr>
<tr>
<td>Latin America/Caribbean</td>
<td>1.6</td>
<td>1.4</td>
</tr>
<tr>
<td>Europe</td>
<td>2.8</td>
<td>3.0</td>
</tr>
<tr>
<td>North America</td>
<td>13.4</td>
<td>5.6</td>
</tr>
<tr>
<td>Oceania</td>
<td>8.2</td>
<td>0.4</td>
</tr>
<tr>
<td>Worldwide</td>
<td>3.4</td>
<td>37.7</td>
</tr>
</tbody>
</table>

*Source: World Contraceptive Use 2005 [Wallchart] (UN 2005)*
Time Trends for Couples Relying on Vasectomy and Female Sterilization Worldwide

![Graph showing trends in vasectomy and female sterilization worldwide from 1982 to 2005.](image)

<table>
<thead>
<tr>
<th>Year</th>
<th>Vasectomy (in millions)</th>
<th>Female Sterilization (in millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1982</td>
<td>30</td>
<td>100</td>
</tr>
<tr>
<td>1991</td>
<td>43</td>
<td>145</td>
</tr>
<tr>
<td>2001</td>
<td>44</td>
<td>211</td>
</tr>
<tr>
<td>2005</td>
<td>38</td>
<td>225</td>
</tr>
</tbody>
</table>
Lack of awareness (least known of the modern methods)

Rumors / myths about masculinity & sexual function
(aka “truths”; ?castration?)

Health concerns (“will make me ‘weak’”)

Anxiety about the procedure

Limited access to services
(FP services geared to women; FP providers mainly female; few vasectomy providers)

Cultural and gender norms
(FP a “woman’s duty”; greater # children = greater masculinity)

Provider / program bias
Vasectomy Promotion Strategies & Messages

- Promote to clients, providers, programs
- Emphasize benefits, e.g.:
  - Provide for your family; love/concern for wife
  - Advantages over other methods (permanence; one act; simpler than FS)
  - Sexual satisfaction
- Address women as well as men
- Use multiple channels:
  - mass media; interpersonal communication; “hotlines”
- Use satisfied clients / vasectomy champions
- “Be like Coke” *(repetition is key to adult learning & behavior change)*
Vasectomy Is as Much a Communication “Operation” as a Surgical Operation
Use Messages Relevant to Men’s Concerns

Vasectomy

All you lose are your worries

Vasectomy is a permanent family planning method for men. It won’t affect your sexual appetite or performance. Ask about this method at a health facility displaying this symbol.
Men as Supportive Partners

Ethiopia and South Africa: Men’s role in PMTCT
Uganda: Men’s role in prevention & care of obstetric fistula
Nepal: Men’s role in Safer Motherhood
Turkey: Men’s support for post-abortion care & FP
### Reproductive Health Behavior:

<table>
<thead>
<tr>
<th>Behavior</th>
<th>Baseline:</th>
<th>Project:</th>
<th>% increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women completing 4 Antenatal (ANC) visits</td>
<td>342</td>
<td>519</td>
<td>52</td>
</tr>
<tr>
<td>Men accompanying partners for ANC visits</td>
<td>66</td>
<td>237</td>
<td>259</td>
</tr>
<tr>
<td>Women delivering at health facility or at home with a skilled birth attendant</td>
<td>149</td>
<td>178</td>
<td>19</td>
</tr>
<tr>
<td>New female family planning users</td>
<td>191</td>
<td>235</td>
<td>23</td>
</tr>
<tr>
<td>Men accepting vasectomy</td>
<td>4</td>
<td>14</td>
<td>250</td>
</tr>
<tr>
<td>Male STI clients seeking services</td>
<td>8</td>
<td>31</td>
<td>288</td>
</tr>
<tr>
<td>Condoms distributed</td>
<td>20,620</td>
<td>56,477</td>
<td>174</td>
</tr>
</tbody>
</table>

Men as Agents of Change

I am a PARTNER in my community...
...I speak out on violence against women 365 days a year.
Family Planning programs need to identify and nurture vasectomy champions at all levels – policy, program, facility, and providers themselves.

At the head of almost every energetic “vasectomy program” is a director who is personally interested in involving men in family planning and who is committed to the program’s success.

At the center of a clinic where vasectomy is provided regularly, is a trained provider who firmly believes in the method.
Closing Thoughts about Fostering Change

- Any development intervention requires behavior change
- Any public health intervention requires behavior change
- Any medical intervention requires behavior change
- I.e., We’re all change agents
- Yet we often fail to factor the principles, dynamics and evidence of fostering successful change into our thinking and programming:
  - Policymakers issue new policies
  - Researchers publish new findings
  - Experts devise new guidelines
  - Programs introduce new or expanded services …

And nothing much changes
“The only people who like change are babies with dirty diapers”

U.S. examples:
- 500,000 unnecessary C-sections, every year!
- 80,000 unnecessary hysterectomies annually
- 11-year lag: Correct treatment of heart attacks
- Non-scalpel vasectomy (NSV):
  > 1972: invented in China
  > 1980s: proven better/main approach in programs
  > 2003: WHO still calling it a “new method”
  > 2004: 51% (only) of vasectomies in U.S. via NSV
Fostering Change in Medical Settings: Key evidence-based considerations

- **Perceived benefit**: most important variable re rate & extent of adoption of new provider (or client, facility, org unit) behavior: “What’s in it for me?”

- “Perceived” = eye of the beholder, the ”changee”

- The greater the perceived **relative advantage**, the more rapid the rate of adoption/change

- Other important variables:
  - **Simplicity** of new behavior
  - **Compatibility** with medical system’s norms, standards, practices
  - Adopter characteristics (Early adopters)
Thank You!