

Reproductive health and AIDS prevention in sub-Saharan Africa: the case for increased male participation

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Reproduction is a dual commitment, but so often in much of the world, it is seen as wholly the woman's responsibility. She bears the burden not only of pregnancy and childbirth but also the threats from excessive child bearing, some responsibility for contraception, infertility investigation and often undiagnosed sexually transmitted diseases (STDs) including AIDS. Failure to target men in reproductive health interventions has weakened the impact of reproductive health care programmes. The paper proposes that sophisticated and dynamic strategies in Africa and elsewhere which target women's reproductive health and research (such as control of STDs including AIDS, family planning, infertility investigation) require complementary linkage to the study and education of men. Men's perceptions, as well as determinants of sexual behavioural change and the socioeconomic context in which STDs, including AIDS, become rife, should be reviewed. There is a need to study and foster change to reduce or prevent poor reproductive health outcomes; to identify behaviours which could be adversely affecting women's reproductive health.

Issues of gender, identity and tolerance as expressed through sexuality and procreation need to be amplified in the context of present risks in reproductive health. Researchers and providers often ignore the social significance of men. This paper reviews the impact of male dominance, as manifested through reproductive health and sexual decisions, against the background of present reproductive health problems.

A research agenda should define factors at both macro and micro levels that interact to adversely impinge on reproductive health outcomes. This should be followed up by well-developed causal models of the determinants of positive reproductive health-promoting behaviours. Behaviour specific influences in sexual partnership include the degree of interpersonal support towards prevention, for example, of STDs, unwanted pregnancy or maternal deaths. Perceived efficacy and situational variables influencing male compliance in, say, condom use, form part of the wider study that addresses men.

Thus preventive reproductive health initiatives and information should move from the female alone to both sexes. Women need men as partners in reproductive health who understand the risks they might be exposed to and strategies for their prevention.

Introduction

In all societies today sexual relationships can be a source of pleasure and reproduction as well as risk to health. This has spurred research into the foundations of sexuality and the gender dynamics that underlie sexual and reproductive health, and into interventions that address the negative health outcomes. Often, community social structures and belief systems, defined and dominated by men, perpetuate

gender imbalances which contribute to poor outcomes in reproductive health.

In sub-Saharan Africa, reproductive health care research and service have assumed increasingly important roles over the past two decades, but men's participation and circumstances have received scant attention. The advent of the AIDS epidemic has brought into sharp relief the absence of information

on men. Whereas traditionally contraceptive practice, in Zimbabwe and elsewhere in Africa, has relied heavily on oral agents taken by women, practising 'safe sex' requires both male participation and cooperation.

Due to patriarchal structures that benefit males more than females, men have often remained passive or non-participatory to probing by researchers or as targets for the dissemination of reproductive health information. Thus little is known about men's perceptions of their roles in reproductive health. Equally, patrilineal societies often have power relations skewed in favour of men and this is also reflected in the realm of sexuality. Thus, historically, both sociocultural perceptions and technological know-how have set the stage for the current disproportionate emphasis on females as agents for fertility regulation and infertility investigation.

In many African countries various institutions have played an important role in spreading knowledge on areas of reproductive health related to family planning and maternal health. This has led to increased knowledge about contraception, ante- and post-natal care, and childbirth. However, this knowledge is selective. Until the AIDs epidemic, information about sexually transmitted diseases (STDs) was not widespread, nor was community-based data on reproductive health practices and outcomes such as maternal morbidity and mortality.

Often, the spread of information about issues in reproductive health is verticalized by programme, e.g. family planning, rather than taking a holistic picture of socioeconomic and reproductive health issues. This frequently leads to people not acting on the knowledge they possess. This is true of contraceptive use, for example, where knowledge is very high but use remains low and family sizes remain high due to socio-cultural, political, economic and gender factors, relating mainly to lack of female control over decisions on fertility.

The emphasis on women in reproductive health research and interventions has also filtered into AIDS prevention and STDs control. Much of the published statistical data on HIV and AIDS in Africa is derived from studies of women's ante-natal care clinics and prostitutes. Whereas such data are important and these populations are readily accessible to researchers, they tend to reinforce stereotyped misconceptions at community level that label STDs as

'females' diseases'; and fertility regulation and infertility as problems in the female preserve. Both STDs control and family planning programmes stand to benefit from a deeper understanding and insight into male reproductive and sexual behaviour, and male education on risks to partner and self.

Social context of STD risk

Traditionally, in many parts of sub-Saharan Africa reproductive decisions remained in the 'male domain'. Women remained recipients of either individual or collective male-based decisions regarding their reproductive health. These historically constructed cultural values were affected by colonialism and the introduction of patriarchal values. This combination worsened the position of women; they were legally reduced to perpetual minority status in the custody of either their fathers or husbands. They rarely had the right to property, land or even to their children, who became part of the male lineage. Using Zimbabwe as an example, before the age of majority legislation of the 1980s, reproductive health decisions required the written consent of the husband or male guardian, even in cases such as tubal ligation on medical advice.

As colonial land expropriation drove African men into the cash economy, the peasant economy came to rely heavily on female labour. Male folk left to work in towns where the majority lived in men only hostels, mines or large-scale farms, leaving women to manage as subsistence farmers. Family separation became an accepted feature of life, changing traditional rules of sexual relationships outside of marriage. The male migrant worker was left to establish other relationships of varying degrees of stability (from the 'city wife' to paid single sex encounters). In this setting, STDs became rife and continue to be so. In 1992, over 1.4 million episodes of STDs were reported in the adult Zimbabwe population.

In Ethiopia Duncan et al. (1992) found genital Chlamydial infection in 62% of women attending gynaecological, obstetrics and family planning clinics. Prevalence of infection was highest amongst those with more than five sexual partners (78%), bar girls (84%) and in lower income groups (65%). Genital Chlamydial infection risk increased in those seropositive for syphilis, gonorrhoea and herpes simplex virus type 2.

Martin et al (1992) reported an association between HIV-1 infection and STDs among men in Central Africa and concluded that the association was simply a marker of promiscuity. Their results, based on 160 STD patients and 95 controls, showed differences in sociological and behavioural parameters as well as in HIV serological status in the two groups. In Tanzania, Nkaya et al. (1991) reported on STD prevalence in prostitutes and found an HIV seroprevalence of 73%. In South West Uganda, HIV seroprevalence was highest in the main road trading centres, at 26% and 47% for men and women respectively, and lowest in rural agricultural villages, at 8% and 9% (Wawar et al. 1991).

More than 4000 women attending family planning clinics in Nairobi (Daly et al. 1994) were studied for risk factors for gonorrhoea, syphilis and trichomonas infection. A low population-attributable risk was found and the authors suggested that behaviour change messages directed to women had a low potential for preventing STDs. Also in Nairobi, Hunter et al. (1994) found that among women who are not in the high-risk groups, risk of HIV infection was largely determined by their male partner's behaviour and circumcision status. A study of male factory workers in Harare, Zimbabwe (Mbizvo et al. 1994) established that few married men, who tested positive for HIV infection, used condoms with their wives although they reported using them with other sexual partners. These findings were corroborated by a Thailand report (Roongpisuthpang et al. 1993) in which there was no identified HIV risk in 69% of HIV positive women reporting for antenatal care, except through their husbands. These examples illustrate the urgent need for interventions designed to change male sexual behaviour.

In a review on reaction to AIDS in Sub-Saharan Africa, Caldwell et al. (1992) assert that there was an under-reaction to the epidemic. This arose from societies' lack of discussion of sexual relations between the sexes and the generations, and from cultural emphasis on the multiple antecedents of misfortune and plural explanations of death.

Sexually transmitted diseases serve as a marker of the extent of multiple or casual sexual encounters. In addition, many researchers believe that the high rates of other STDs may explain the apparent efficiency of heterosexual transmission of HIV in Africa. As consumers of health services and family planning techniques, women may often be more accessible to

health education and researchers than men. However, as loci of sexual behaviour change in light of the STDs and HIV epidemic, or indeed fertility control, they may have the most limited options. Thus prescriptions that promote change in sexual behaviour must take into account women's constraints.

Insights into factors shaping male sexual behaviour should facilitate the design of strategies which promote their compliance. There is a need to define sexual behaviour in the context of rural/urban migration; enhanced legal status of women; the AIDS epidemic; and with men and women as equal partners sharing the responsibility for STD and fertility control in reproduction.

STDs risk awareness and sexual behaviour

Most of our knowledge on male sexual behaviour and health comes from the study of STDs and HIV. Male sexual practices and their responsibility in supporting their female partners received less attention in fertility and reproductive health research, including male acceptance of female-based methods. In the area of STDs, the continued high prevalence, with resultant high rates of female and male morbidity and mortality, underscores the importance of understanding sexual behaviour.

At an STDs referral centre for both males and females in Harare, a total of 10 196 patients were seen during 1990. The majority of referrals were for primary, recurrent, or chronic genital ulcer diseases comprising chancroid (29%), genital herpes (6.37%) and lymphogranuloma venereum (1.5%). The association of genital ulcerative diseases with the efficiency of HIV infection and transmission has been widely documented (Daly et al. 1994; Laga et al. 1994; Hunder et al. 1994; Bassett et al. 1990). The control of STDs and consistent condom use are considered valuable and cost-effective interventions for containing the spread of HIV. In the study by Daly et al. (1994) risk factors for HIV seroconversion after multivariate analysis included irregular condom use, gonorrhoea, trichomoniasis and genital ulcer disease (RR 2.5, 95% CI 1.1–6.4). In 1992, the Harare City Health Department reported that AIDS was the leading cause of adult deaths, accounting for about one-quarter of all deaths (City of Harare, 1992 Annual Report).

The appearance of AIDS within the STDs spectrum brought into focus the role of behaviour in the sexual

transmission of disease amongst both heterosexual and homosexual contacts. It has considerably altered the landscape in regard to sexuality and contraception as it is increasingly recognized that appropriate contraceptive methods depend upon the sexual behaviour of the user. The importance of preventative behaviour counselling has been highlighted.

Correlates between mode of HIV infection and sexual behaviour prompt the studying and understanding of community perceptions of risk and the prevailing sexual practices. Most studies concerning STDs and AIDS in Africa have focussed on commercial sex workers (Kreiss et al. 1986; Mann et al. 1988) and other selected high-risk groups such as military camps personnel, with little focus on sexual behaviour, especially amongst comparable groups conceived to be non-risk. Whereas women in the sex industry could be exceedingly vulnerable to such infections, they constitute a minority of the total population at risk for infection.

Findings from an HIV clinic in Harare (Latif et al. 1989) reported a high rate of concordance (60%) amongst couples in whom the male partner was the index case. A history of genital ulcers was three times more likely among men in couples where HIV infection was concordant rather than discordant. On the other hand, there were only 10 female positive/male negative couples of the 4000 patients seen (Bassett et al. 1990). Could the high rates reported from women in antenatal care clinics be a reflection of sexual behaviour by their male partners?

In a case-control study of risk factors for HIV infection by Bassett et al. (1990), 75% of seropositive male factory workers in Harare reported a past history of sexually transmitted disease, with 70% having had sexual liaisons outside their primary relationships and 60% having paid cash for sex on at least one occasion. In a prospective cohort study of infertility secondary to STD infections, 77.8% of male STD patients (Mbizvo 1990) reported having paid cash for sex at least once. Infertility was present in up to 10% of the STD patients seen.

In a stratified cluster random sampling of Zimbabwean men (Adamchak et al. 1990), nearly 90% had heard of AIDS, 60% knew it was fatal, but only 8% reported that they would use condoms in order to avoid AIDS. Although 61% of men indicated that they changed their behaviour in order to avoid contracting AIDS, approximately 39% either reported

a behaviour that did not reduce risk or failed to report a behavioural change. Despite STDs knowledge being high, 50% had a history of an STD within the preceding five years and 40% reported having had sexual partners outside marriage during the year before the survey. Furthermore, 75% reported having had extramarital sexual encounters with commercial sex workers; thus pointing to a gap between sexual behaviour and risk awareness on the studied indicators.

Current condom usage was reported by only 7% of the same sample, although they were more likely to be used by partners of women who were more educated and lived in urban areas, with reported usage rates of 12.0 and 16.8% respectively (Mbizvo and Adamchak 1992). Indeed, the existing data suggested that, at least in many males, sexual behaviour could be predisposing to the risk of STDs and HIV infection.

Contraception decision making

Most data concerning family planning have focused on the study of contraceptive knowledge and adoption amongst women. The findings point to a disproportionate emphasis on methods that target the female partner. In Zimbabwe, 53% of men reported having knowledge of female sterilization against only 2% with unprompted knowledge of male sterilization (Mbizvo and Adamchak 1991). The study also demonstrated that marriage was practically universal and, whereas contraceptive prevalence was high, in the majority of cases (64%) men had responsibility for deciding on contraceptive adoption and family size.

Discussion on family size preferences has been shown to take place in families where the male partner had more years of schooling compared with less-educated men (Adamchak and Mbizvo 1991; Gibney 1993). In the study by Gibney, only 58% of married men with 0-7 years of education had discussed the number of children with their spouse whereas 100% of men with 13 or more years of schooling had. Similarly, while 55% of women with 0-4 years of schooling had discussed family size, 87.5% of women with 13 or more years had. Educational attainment and discussion of family size was significant ($p = 0.014$) for males, but not for females.

The female bias in the promotion of family planning programmes is an issue in most African countries,

as men play the dominant role in deciding whether their wives can initiate the use of contraceptives and whether their adolescent children can receive information on reproductive and sexual health. Increasing male involvement in family planning should not distract efforts to improve the status of women, but should enhance communication within relationships and foster shared responsibility in the reproductive health process.

In a study in Ghana, Ezeh (1993) concluded that spousal influence, rather than being mutual or reciprocal, was an exclusive right exercised only by the husband. A young woman in the study reported 'when I wanted to do family planning my husband did not allow me, so I did not do it'. A man further commented 'in my view, the women has no legitimate right . . . it is God who grants children, the woman has no right to choose the number of children she prefers . . . it is you the man, who decides to have sex with her'.

In the view of Malcom Potts, President Emeritus of Family Health International, USA, 'The forgotten 50% of family planning are ready to take part if only asked'.

The Ministry of Health and Social Welfare in Burkina Faso (McGinn et al. 1989) believes that men are open to learning about using modern contraceptives but have concerns about family planning. They are reported to fear losing their children to the all too familiar ravages of disease. They fear the new drugs and devices which, according to them, are reputed to harm their users, and fear also that their use may change the balance of social control between men and women.

The Planned Parenthood Association of Zambia (PPAZ) targeted men for family planning both to increase their participation and to take advantage of their influence in those matters (Chirranbo 1992). In Bangladesh a project to introduce Norplant (Ahsan 1992) attempted to include men in the counselling process. Preliminary findings suggested that continuation rates at 24 months were significantly higher for women whose husbands were counselled, compared with women whose husbands were not.

According to the 1988 Zimbabwe Demographic Health Survey (ZDHS) contraceptive prevalence had increased to 43% of married women aged 15–49, with 36% using modern methods and 7% traditional

methods. The Zimbabwe Male Fertility Survey (ZMFS) (Adamchak and Mbizvo 1990) reported a contraceptive prevalence of 45%, with modern methods accounting for 38% of methods used and traditional methods 7%.

In terms of decision-making regarding use of contraception, women in the ZDHS reported that men were more often responsible for the decision to use contraception than the women themselves, although women were far more likely to actually obtain information and use contraceptives. Further, two out of three women reported that they had discussed contraception with their spouse at least once during the year.

Although the data on STDs suggest that male behavioural patterns are entrenched, some data regarding decision-making suggest that men are amenable to change. For example, the Zimbabwe Male Motivation Project (Piotrow et al. 1992), which collected prospective data on 892 men, found that men exposed to a multimedia promotional campaign were significantly more likely than other men to decide to use family planning and to say that both spouses should decide on family size.

The above studies confirm the role played by men in either facilitating or inhibiting the adoption of family planning and endorse the adoption of strategies that include men in family planning promotion programmes.

Condoms acceptance and HIV risks

Only 7% of men in the ZMFS reported that they had ever used a condom. The vast majority (90%) reported use of the oral contraceptive pill by their partners as the most common contraceptive method. In a study of male factory workers in Harare (Mbizvo et al. 1994) only 5% used condoms all the time. The men using condoms more than once were younger or had more education. Only 24% of married men reported using condoms with their wives despite HIV positive sero-status of 19% in the cohort and the majority of the married men reporting having girlfriends or mistresses.

Traditionally, men associate condoms with reduced pleasure (Mbizvo and Adamchak 1989) or prostitution (Caldwell et al. 1987). In some cultures condoms are associated with promiscuity and their association with disease prevention is seen as a draw back to their

use with the wife (Rwabukwali 1991) or to their public promotion. Disparity between knowledge and use of condoms has been reported in many other studies (Lampthey et al. 1978; Kirumira 1991; Sekadde-Kigonde et al. 1991). Use of the condom to prevent infections accords it a role other than just contraception. Prior discussion of condom use could be misconstrued by either partner as admission to having other partners. Male cooperation, compliance and consistence often determines the rate of success of condom use for both purposes.

In a knowledge, attitudes and behaviour (KAP) study by Wilson et al. (1987), only 10–20% of trainee teachers could correctly identify modes of HIV transmission. Self-reported sexual behaviour amongst secondary school pupils (Wilson et al. 1989) indicated considerable sexual activity amongst males, with 46% indicating that they were sexually experienced and nearly 16% reporting coital experience with a prostitute. Three per cent of female students reported that they were sexually experienced. Other studies among urban adults revealed that whereas knowledge of AIDS was nearly universal, preventive behaviour or condom use was not nearly as common (Wilson et al. 1988; Laver 1988). Further, much of the research and interventions have focused on groups considered to be at higher risk, such as sex workers, their clients and truck drivers (Wilson et al. 1989). However, while the acquisition of HIV infection might have been linked to particular cluster groups at the earlier stages of the epidemic, this is no longer the case as individual risk behavioural profiles continue to place at risk individuals outside these groups.

Infertility investigation

Programmes that offer family planning services need to incorporate both fertility regulation and infertility management. Thus programmes concerned and offering care on either side of fertility regulation are more likely to have a more positive impact on reduction of total fertility rates. In most indigenous populations of sub-Saharan Africa, infertility is considered a source of great misery and emotional stress. Demographic studies by Belsey (1976) found rates of childlessness among couples aged 50 years and above of 32% in Gabon, 18% in Zaire, 14% in the Central African Republic and 10% in Sudan. Increasing discussion on fertility differentials has focused on sub-Saharan Africa where Frank (1983) has concluded that infertility accounts for 60% of the among country variation in total fertility. Caldwell and

Caldwell (1983) attribute most of the African differential to STDs, probably gonorrhoea.

Infertility is considered a social stigma which can lead to family break-up. Men are almost always assumed to be fertile. Thus, the psychological burden of coming to terms with infertility is more strenuous in men. The engendered feeling of inadequacy often leads to portrayal of the woman as the infertile partner. Often the female partner presents first for medical advice. However, given the readily available means with which status of male fertility can be established with semen analysis, it is plausible to investigate the male partner as a first approach in infertility management.

Research agenda

Research findings in the region point to specific socio-cultural and economic factors that underlie negative reproductive and sexual health outcomes. STDs risk awareness, pregnancy planning and STD prevention programmes are much more likely to succeed if male commitment is solicited. In order to draw up such programmes, there is constant need to understand the dynamics of social interactions, of sexual relationships and the decision process; the empowerment of women to negotiate safe sex; the determinants of preventive behaviour or behavioural change; the socioeconomic and cultural context of risk versus non-risk sexual behaviour; the determinants of condom acceptance; the impact of health education on subsequent sexual behaviour; the context in which STD transmission continues to occur; and community perceived relevant interventions for reducing the spread of STDs including AIDS.

The decision process in family planning, fertility and sexuality is an aspect of gender closely related to prevailing socio-cultural and economic milieu. Changes in attitudes are likely to be influenced by changes in the economic sphere, which are usually subsumed within the concepts of development, modernization, urbanization, industrialization, and exposure to media or education. There is a need to understand and foster shared responsibility in fertility regulation and family planning.

Barriers to explicit spousal communication on sexual needs and risk of infections need to be investigated. Without a deeper understanding of how sex is viewed, how it's negotiated and how it takes place, attempts to intervene and change the course of the

STDs/AIDS epidemic will founder. Well-intentioned exhortations by women to change sexual practices, such as use of condoms or avoiding multiple partners, may fly in the face of reality for these women. Simultaneous health education campaigns that target men are needed.

In many countries today, many people may recognize the threat to reproductive health posed by STDs and the fatality of AIDS. However, appropriate attitude and behaviour change may not necessarily follow. Information on unsafe sex and the possibility of HIV infection in different socio-cultural settings requires greater clarification. For example, would a respondent use a condom if his brother, friend, teacher, girlfriend or wife told him to do so? Situational variables such as the likelihood of using condoms following alcohol consumption should be included.

To pursue deeper understanding of sexual behaviour, research should employ a range of data collection methods. Qualitative methods, in-depth interviews using recall prompts (such as calendars), and focus group discussions promise to yield more substantial information on actual behaviour norms and values. These approaches should form an important complement to survey techniques.

Constant monitoring of the socioeconomic contexts leading to poor reproductive health, and the determinants of behavioural change, is needed. Research must be done into needed male support systems, and the challenges in reproductive health confronted, such as controlling STDs, reducing unwanted pregnancy, reducing maternal mortality at community levels, and increasing access to fertility regulation and infertility management.

Conclusions

There remain major gaps in our understanding of male perspectives and gender differences on issues pertaining to sexual and reproductive health. It is difficult to define the norm in sexual patterns in many African countries. The social change, family disruption and poverty, intersection of traditional and modern practices and the paucity of research on sexual issues have made this an area where most publicly pronounced norms are probably not practised by the majority, and there is thus a gap between norm and practice. Behavioural response to new knowledge is key to the prevention of multiple factors adversely affecting reproductive health. The

AIDS risk, like other STDs, is a result not only of biological factors but also social, psychological, economic and interpersonal power structures that determine behaviour. There is a need, at micro-level, to review some culturally and historically constructed gender roles, concepts of parenthood and the individual psychodynamics. In response to the epidemic, it is imperative to usher new cultural prescriptions into the wider social system. The multiplicity of factors calls for interdisciplinary approaches to preventive strategies, taking into account the prevailing socioeconomic settings. Institutions that cater for the public sector and donor agencies need to address the negative effects of the infrastructures and the constraints to change. Prevention is our best hope, given the limitations of current medical interventions. The challenges we face include the mobilization of positive cultural factors and preventive health education efforts.

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