

**MALE PARTICIPATION IN SEXUAL AND REPRODUCTIVE HEALTH:  
NEW PARADIGMS  
SYMPOSIUM REPORT**

**Oaxaca, Mexico  
October 10–14, 1998**

**AVSC International and IPPF/WHO**

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AVSC and IPPF/WHR are committed to continuing our journey of discovery, exploring new paradigms for men's involvement in sexual and reproductive health, with our partners around the world.

## EXECUTIVE SUMMARY

AVSC International and International Planned Parenthood Federation/Western Hemisphere Region (IPPF/WHR) hosted a conference entitled “Male Participation in Sexual and Reproductive Health: New Paradigms,” in Oaxaca, Mexico, October 10–14, 1998. One hundred service providers, policymakers, program directors, and donors from 19 countries in the Americas came together to share information and recommendations regarding men’s participation in sexual and reproductive health. Seven panels with 22 speakers presented papers on various aspects of masculinity, sexuality, violence, and fatherhood. They discussed sustainability and the challenge of finding resources. Panelists had a wide range of research and program experience in masculinity/ies, sexuality/ies, adolescent development and sexuality/ies, prevention of sexually transmitted diseases, HIV and AIDS, violence, and fatherhood. Ten working groups explored these themes further, and participants shared their programmatic experiences during a poster and video session.

The symposium was linked to commitments made at the International Conference on Population and Development (ICPD) held in Cairo in 1994, and at the Fourth World Conference on Women (FWCW) held in Beijing in 1995. In Cairo, participants agreed that “men play an important role in achieving gender equality, since in most societies, they exercise preponderant power in nearly every sphere of life, ranging from personal decisions regarding family size, to all levels of political and program decisions” (ICPD). The Beijing Conference called for men and women to take “responsibility for their sexual and reproductive behaviour” (FWCW).

As part of the commitment to implement agreements reached at these conferences, the objectives of this symposium were to:

- Create a forum to discuss ways in which men can constructively participate in the care of their own sexual and reproductive health, as well as that of their partner
- Increase the knowledge of workshop participants about male participation in sexual and reproductive health and gender equity
- Provide ideas and materials to initiate, reinforce, and evaluate programs that promote male involvement and gender equity in relation to sexual and reproductive rights
- Create and share strategies to overcome gender stereotypes in sexuality and reproductive health
- Enhance donor interest and support for initiatives that focus on male participation in sexual and reproductive health in the region
- Develop country plans that define specific future actions within each country to foster the involvement of men in sexual and reproductive health

Results achieved at the symposium include:

- Institutional and country action plans that explore strategies for involving men in sexual and reproductive health

Evaluation of the symposium and preparation for a 9–12 month assessment to measure the effects of this conference on research, programs, and policies

A strengthened commitment to work toward gender equity

The opportunity for men and women to work together, share personal experiences, strengthen professional networks, and explore new ideas and strategies to increase men's constructive involvement in reproductive health

Collaborative participation by governments, nongovernmental organizations (NGOs), and donors

An expression of support for a Declaration Against Violence Toward Women

AVSC International and IPPF/WHO are committed to continuing support of work with men in the region.

## INTRODUCTION

This symposium, entitled “Male Participation in Sexual and Reproductive Health: New Paradigms,” brought together health care professionals as well as representatives from governments, donor agencies, and nongovernmental organizations (NGOs) in the Americas who share an interest in sexual and reproductive health programs that promote gender equity. They explored the need to dismantle inequitable power relations between men and women and suggested possible alternatives for fostering greater equality. The agenda moved from presentations on current theories about masculinity/ies and sexuality/ies to concrete programs in which men can learn to redefine themselves and their roles in a more equitable way and can share in family responsibilities, including contraception and child care. Several working groups met to discuss themes presented in plenary sessions in greater detail.

***“We are looking for men to become partners in supporting power for women.”***

**— Oscar Contreras**

The tension between conducting more research on unanswered questions and taking action to initiate the necessary services and programs prevailed throughout the symposium, but was particularly apparent in discussions about programs. This tension challenged participants to face the complexity of integrating men into sexual and reproductive health services. Extra time was taken in small working groups to try to bridge the gap between research and action in individual country contexts.

***“When the problem is so serious, you can’t wait for more studies.”***

**—José Aguilar Gil**

There was general agreement that, in most countries, a first step in involving men in sexual and reproductive health programs is to examine and redesign research instruments to collect data on men’s needs, desires, and behaviors. Participants asserted that, although many service providers, health care professionals, and policymakers have acknowledged the pressing need to involve men as partners and clients in their own right, it is not easy to involve men in a health care system that was established for women. As is the case when focusing on any new population for health care services, baseline research is needed to assess the status quo. Demographic and health surveys are only beginning to collect information about men and their reproductive behaviors. Mexican participants asserted that demographers in their country must redesign studies to collect and disseminate data on men. Colombian participants noted that in the 20 localities of Bogotá, it is extremely difficult to collect data on men as clinic registration forms are designed for women. All of the participants also agreed that quantitative methods of research are insufficient in assessing needs with regard to men’s involvement in reproductive health.

The Working Group on Conceiving Programs for Men proposed that people conducting research should use a combination of qualitative instruments, including focus groups, case studies, and in-depth interviews with couples, in order to capture the gender dynam-

ics that can affect service delivery. Participants agreed that the ability to collect meaningful data and assess needs is imperative for developing effective programs for men.

There was universal consensus that, in initiating programs to involve men, service providers must clearly define their objectives and priorities. Services for men could range from including men in prenatal care to providing specific clinical services such as vasectomy and prostate surgery, and participants questioned which services for men are necessary and appropriate. In brainstorming the different types of services that a comprehensive male-involvement program would provide, participants came up with six major categories: parenthood, fertility regulation, reproductive cancers, sexually transmitted diseases (STDs)/HIV, physical and sexual violence, and sexual therapy (Working Group on Conceiving Programs for Men). Although participants asserted that there is a need for services such as those mentioned above that are specific to men, they recommended integrating such services into preexisting programs. According to the working group on conceiving programs for men, integrated services have proven to be much more cost-effective and sustainable than male-only clinics.

Several panelists presented programs that addressed behaviors that are influenced by the normative model of masculinity, including sexuality, violence, and fatherhood. They emphasized the importance of not objectifying men as “risk factors” or “problematic partners.” Instead, providers must create a positive and safe atmosphere in which men can comfortably participate. In some cases, existing clinics may be equipped to address these needs. In other cases, program managers may need to create new spaces outside the clinic setting. Although participants agreed that providers should avoid an accusatory perspective when working with men, they also focused on the need to work with men on the prevention of disease and unsafe sexual behavior.

While research and programs, as well as working-group discussions, confirmed that working with men is essential, some participants were concerned that men’s sexual and reproductive health programs could compete for limited resources with programs for women. However, participants noted that good programs for men involve a gender perspective and respond to the needs of both men and women. Donors and providers pointed out that requests to involve men in reproductive and sexual health programs often come from poor rural and urban women, who have been asking reproductive health care providers to involve their partners, particularly in family planning, but also in prevention of STDs and AIDS.

***“Health is priceless, but services cost.”***

***— Milton Cordero***

Throughout the meeting, participants examined the reasons behind involving men in sexual and reproductive health. The Working Group on Conceiving Programs for Men agreed on the following four basic principles for programs with a sexual and reproductive health mandate that clarify the importance of involving men:

#### **Four Basic Principles for Sexual and Reproductive Health Programs**

1. Recognize men as individuals with their own specific sexual and reproductive lives and needs

2. Establish programs with the goal of transforming gender roles to achieve more equitable relations between men and women
3. Acknowledge that programs must attend to all of the sexual and reproductive health needs throughout a person's life cycle
4. Ensure that programs focus on a concept of quality that is rooted in the needs and desires of both men and women

### **Country Action Plans**

In the interest of transforming their valuable discussions into action, participants divided into regional and country groups on the final day to draw up plans of action that would further the cause of male involvement in their own countries. These plans outlined steps in four crucial categories of action: research, communications, services, and policy and legislation. Examples of the proposed plans are included in a chapter at the end of this report.

### **Structure of This Report**

This report summarizes research results and programmatic information shared among participants as well as recommendations and actions suggested in plenary sessions, working groups, and country action plans. It is thematically organized to highlight the topics of masculinity/ies, sexuality/ies, STDs/HIV, violence, and fatherhood, while illustrating these discussions with initial program experiences. Parenthetical citations refer to presentations made by panelists as well as to the discussion that followed panels and occurred in working groups. Two other documents—a literature review and five case studies—were prepared for the symposium and provide additional theoretical and programmatic information that complement this report.

## NEW PARADIGMS

Paradigms are models of the values, methods, knowledge, relationships, behavior, and beliefs that have been internalized in our societies (Parker).<sup>1</sup> Societal changes of greater mobility, expanded educational opportunities, and the impact of the women's and gay and lesbian movements are forcing a reexamination of traditional paradigms, especially those related to gender. Gender equality requires defining new paradigms that, unlike our current models of masculinity and femininity, are not predisposed to inequality (Figueroa).<sup>2</sup>

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**To attain gender equality,  
we must define new para-  
digms that, unlike our current  
models of masculinity and  
femininity, are not predis-  
posed to inequality.**

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“Once we begin to de-sensationalize the differences between men and women, we can begin to agree on which characteristics or principles of existing models are viable and should be included in a new paradigm”(Figueroa). Some propose that a progressive model of masculinity might include characteristics such as being respectful in intimate relationships, negotiating intimate relationships on the basis of equality, believing in equity in gender roles, actively participating in parenting, and being responsible for sexual and reproductive health decisions (Barker).<sup>3</sup> Promoting more progressive models means adopting new paradigms of service provision as well.

Initial research suggests that services that cater to the rational, technical side of a person are inadequate and must be expanded to address the sociocultural dimensions and structures of inequality that also influence human action. This implies training service providers at all levels in disciplines that are not perceived as being directly related to health under the operating paradigm. For instance, a new paradigm might require providers to learn about the socioeconomic and ethnic culture, provide integrated care, treat the couple or “family,” and address sexuality, while keeping in mind the context within which clients live (Granulles).<sup>4</sup>

Whatever new models are created, professionals working in sexual and reproductive health and gender equity have to contemplate how the models correlate with human rights and the relationships between individuals.

Symposium participants sought to determine how old paradigms of masculinity were created and how they are replicated in order to be able to define new paradigms and propose ways to move towards them. Individuals tend to adopt new paradigms, or adopt less restrictive paradigms, through intimate relationships with partners or friends who

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<sup>1</sup> Richard Parker, “Masculinity, the Male Body, and Erotic Desire.” Presentation.

<sup>2</sup> Juan Guillermo Figueroa, Panel Commentator.

<sup>3</sup> Gary Barker, “Multiple Paths toward Change: Progressive Men in a Macho World.” Presentation.

<sup>4</sup> Roberto Granulles et al., “Argentine Adolescents: Teen Male Experiences in STD and HIV/AIDS Prevention.” Presentation.

## Old vs. New Paradigm in Health Care Provision

Old Paradigm	New Paradigm
Specialized care: Concerned with one aspect of the person	Integrated care: Concerned with the whole person
Emphasis on theory	Emphasis on human values
Professional emotional neutrality	Attitudes of professional play a role in healing
Interventions grounded in accepted methods and dominant beliefs	Varying interventions with appropriate technology complemented by a wide spectrum of noninvasive techniques and nonaddictive medication
Sickness and disability seen as separate components or defective parts	Sickness and disability seen as interactive holistic processes
Patient is treated outside of his/her context	The person is treated as a whole, as part of a family, social sphere, etc.
Intervention to eliminate symptoms and illness in accordance with theoretical-statistical criteria	Intervention to reach maximum well-being, (meta-health) in accordance with the needs of the individual
Patient is dependent and receives treatment	The person is or should be autonomous
The professional has and is the authority	Patient and professional collaborate
Mind and psychosocial are secondary factors and/or are disassociated with organic and infectious factors	Mind, psychosocial, organic, and infectious factors are interdependent
Health is determined by the absence of illness	Health is determined by the presence of well-being

SOURCE: Roberto Granulles et al., "Argentine Adolescents: Teen Male Experiences in STD and HIV/AIDS Prevention." Fundación para Estudio y Investigación de la Mujer. Buenos Aires, Argentina.

present nontraditional gender roles (Parker). For instance, when men are in a truly intimate relationship they can rediscover their ability to be caretakers (a behavior they have exhibited as children), to have empathy, and to learn to be more democratic in their relationships. They may also be more likely to express their emotions and embrace them (Barker).

## MASCULINITY/IES

Masculinity, like gender, is a socially defined construct influenced by myriad forces including history, culture, religion, and economics. Studies confirm the existence of a normative or “hegemonic” model of masculinity accepted by men and women that determines unequal relationships between genders and increasingly elicits a range of negative reactions among men, such as tension, discomfort, conflict, and repudiation (Olavarría and Valdés).<sup>5</sup>

Because of societal changes, particularly gains made by the women’s movement and the gay and lesbian movement, men and women are facing the fact that a rigid construct of masculinity is no longer viable and is increasingly painful for men to follow. Both men and women realize that to achieve gender equality, men need models of masculinity that allow them to feel comfortable in exhibiting behaviors that are prohibited by the hegemonic masculine model.

Male identities are partially created in the process of individuation that young males go through in an effort to define themselves as separate from their mothers. Strict gender

***“There is a new kind of machismo among youths. They are progressive, but when they get married they return to the model of their fathers.”***

**— Juan Carlos Hernandez**

roles are internalized, and boys learn to divorce themselves from qualities they identify as feminine: passivity, weakness, illness, dependence, and sensitivity (Barker; Olavarría and Valdés)<sup>6</sup>. Although boys at play demonstrate a desire and capability to be caretakers, this characteristic disappears during their socialization in a world

in which a hegemonic model of masculinity emphasizes power, autonomy, strength, rationality, and controlled emotions.

Men are expected to be active, productive, competitive, and outwardly oriented (Barker; Olavarría and Valdés). There is a prototypical profile of the male body that corresponds to the hegemonic model of masculinity: it must be active, strong, and capable of physical labor; it must be able to fight in wars and penetrate a woman’s body. Those men who do not match the ideal physique are immediately considered inferior and therefore subordinate (Olavarría and Valdés).

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**There is not one, single universal construct of masculinity, instead there exist masculinities.**

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Few men, however, are able to live up to all of these principles throughout their lives. Initial research indicates that men’s adherence to these characteristics is fluid, changing during their life cycle and varying according to their personality (Olavarría and Valdés).

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<sup>5</sup> José Olavarría and Teresa Valdés, “Studies of Masculinities in Latin America: Issues from the International Agenda.” FLACSO-Chile. Presentation.

<sup>6</sup> Gary Barker, “Multiple Paths toward Change: Progressive Men in a Macho World.” Presentation.

What this indicates is that, in reality, there is not a single universal construct of masculinity, instead there exist *masculinities* (Olavarría and Valdés).

The hegemonic, “normal” model of masculinity is so pervasive that many believe the characteristics and behaviors associated with it are “natural.” The mistaken belief that masculinity is a biological construct encourages many people, especially those most vested in preserving this paradigm, to label men whose physical appearance, sexual orientation, or behavior do not meet the requirements as “biologically deviant.” Under the assumption that these gender roles are universal and absolute, men who do not strive to live up to the demands of this model, regardless of the cost to themselves, their partners, their children, and their community, are branded as feminine or homosexual. Thus, men who disregard and/or reject masculinity as defined by these norms find themselves in a precarious situation and are constantly threatened by those who do try to live by this model.

Still, in spite of the diversity among men, the consequences of not living up to the ideal model of manhood is so frightening that men continue to pay the price of poor health and even death to prove their manliness. Researchers have observed that few men are successful in repudiating the hegemonic model because it enables them to enjoy power over women and over men who are considered inferior because of their ethnic background, financial circumstances, and/or sexual orientation (Barker; Olavarría and Valdés).

Despite the fact that men have historically exercised physical, political, and economic power over women, or perhaps because of it, men strive for more power to express their masculinity. In order to attain and/or maintain their position of power, they often resort to verbal, emotional, or physical violence involving their partners, other men, and in extreme cases, themselves (Olavarría and Valdés). Men derive their identity from their role as providers, producers, and protectors. This enables them to control and subordinate others, whether they are family members (women and children), other workers (who earn less), or members of their community (who are under- or unemployed) (Olavarría and Valdés). Achieving gender equality requires supporting alternative models of masculinity that are not necessarily in opposition to models of femininity and which allow men to behave in ways that foster equality between men and women. These models could include showing emotions and sharing reproductive responsibilities, namely contraception, child-care, and financial welfare (Working Group on Masculinities and Fatherhood).

The study of masculinity/ies is in its preliminary stages. Professionals from diverse backgrounds, including social science researchers, program administrators, and sexual and reproductive health care providers, are beginning to explore the characteristics associated with masculinity/ies in an effort to provide quality services that meet men’s needs. The study of masculinities aims to increase providers’ understanding of men, thereby strengthening the provision of those services intended to improve men’s sexual and reproductive health while fostering gender equality. One example of current research that provides some clues about the process of change and adoption of viable gender models is a comparative study of young men in the *favelas* of Rio de Janeiro and a slum in Chicago. The study suggests that intimate relationships and/or the presence of people who present alternative gender models can be important factors in convincing men to be more “progressive”—that is, to accept more flexible gender models (Barker).

Symposium participants wanted to learn more about masculinities and the possibility of working with men to raise their consciousness about the hegemonic model and its constraints. Participants discussed the important connection between understanding the male construct, assessing men’s needs, and providing quality care services for men. One of the challenges of involving men in sexual and reproductive health is the difficulty of attracting men to health clinics, when the majority of men reject the notion of illness and the services associated with it.

### ReproSalud Project

One example of a program for men that addresses masculinities is ReproSalud, a collaborative project for men and women in Peru run by Manuela Ramos, a Peruvian feminist organization, and Salud y Género, an NGO in Mexico. Oscar Contreras, of ReproSalud, and Benno de Keijzer, co-director of Salud y Género, presented the results of this project. ReproSalud began as an effort to improve the reproductive health of women in impoverished rural and urban areas. Its principal objective is to enable women in these communities to increase their capacity and opportunities to access resources and to direct their own projects in the areas of reproductive health and income generation. ReproSalud works in seven different regions of Peru that span four different languages (Spanish, Quechua, Aymara, and Shipibo). At the request of the women participating, the project was expanded to involve their husbands.

***“The personal development of women implies the progress and well-being of the whole family.”***

**— Oscar Contreras**

### Methodology

When selecting districts for intervention, ReproSalud investigates which communities have the greatest needs. Within a given district, ReproSalud will convene a meeting of the various community organizations working with women. One of these community-based organizations (CBOs) is chosen to be ReproSalud’s local partner in implementing the project and various subprojects. Before designing the project, ReproSalud and the CBO conduct a baseline study in which women in the chosen community do self-assessments and select priority areas of intervention.

<b>Priorities Identified</b>	<b>Number of Women</b>
Vaginal discharge ( <i>Regla blanca</i> )	44
Too many children	27
Suffering during childbirth	14
Mistreatment/violence	2
Abortion	2
Prolapse	2
Menopause	1
Adolescent pregnancies	1
Vaginal swelling	1
<b>Total</b>	<b>94</b>

At the outset of this collaborative project, women from the 85 CBOs that were convened identified the priorities for intervention which appear in the above table.

After identifying these priorities, the women from the local organizations requested that the project involve both husbands and children since some of these health issues concern them.

### ***Designing Workshops for Men in the Community***

In order to respond to the requests of these women, ReproSalud redesigned educational materials and workshops to work with men in the community. Based on self-assessments completed by male participants, ReproSalud identified four topics of major interest to men in these communities:

- The male role in power relations
- Recognizing the costs of that role to themselves, their wives, and their children.
- The pain caused by the process of male socialization
- The advantages of change

Project facilitators built on the methodology used in working with women to design workshops for working with men. The first series of workshops involved the following exercises:

- Self-assessments
- Visualization exercises to explore the various phases of sexual development
  - Workshop facilitators discovered that this was the first time many of the men had talked about and shared these thoughts and feelings in a noncompetitive manner.
- Thinking about the five basic emotions
  - This is an important exercise because it involves the deconstruction of the feelings evoked by emotions in order to call attention to the fact that the feelings are neither “masculine” nor “feminine.”

The second series of workshops included the following topics:

- Sexual anatomy and physiology of men and women
- Sexually transmitted diseases and infections (STDs/HIV), cervical and prostate cancers)
- Contraceptive methods
- Fatherhood
- Men and change
- Disseminating this information on a larger community level
- Testimony on how participants implement what they learn on a personal level

### ***Opportunities and Challenges Identified***

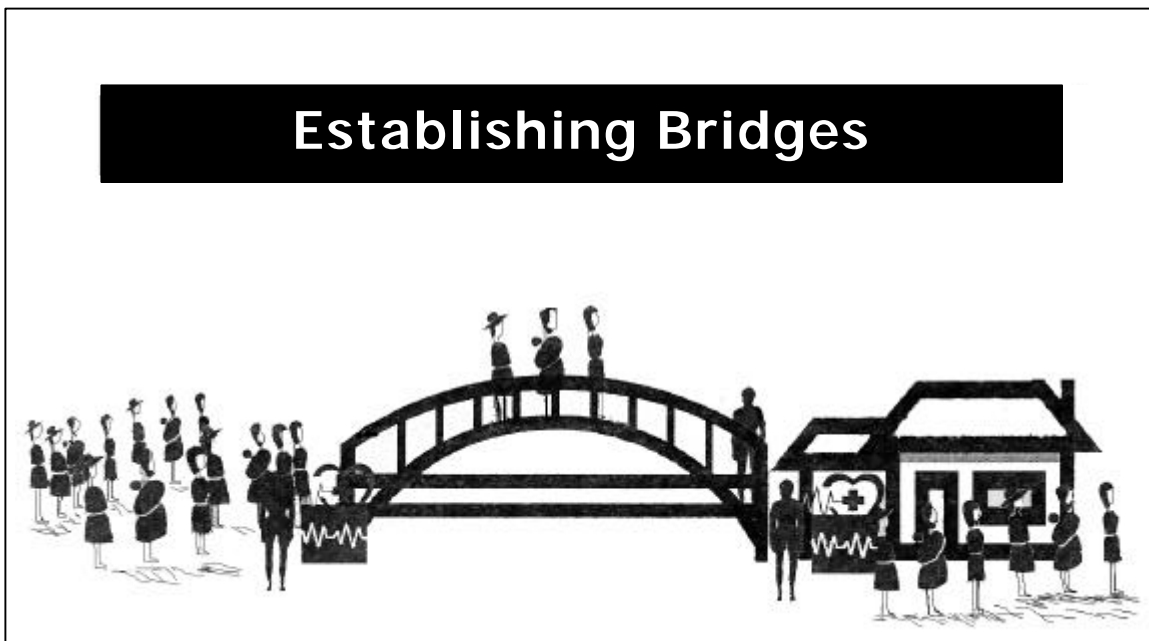
In conducting the workshops, project facilitators found that men were very interested in the information provided and in the exercises involved in the workshops. They had a great desire to learn. In addition, though men noted that the average number of children among them was more than four, once these men received information and education regarding contraception, they tended to express

***“Be careful with mixed groups when power is unequal—the men don’t let the women talk.”***

***— Benno de Keijzer***

their support for it. The workshop facilitators also discovered that men in this region were already quite familiar with the experience of childbirth, since most of their children had been born at home. As a result, they were open to learning more about how to participate in the process, identify warning signs, and assist their wives in general. In addition, since women in the CBOs direct ReproSalud's projects, a local CBO was responsible for supervising male participation. The project facilitators found that men in the communities were willing to work with the CBOs.

Despite the men's willingness to participate in the project, many prejudices remain. The majority of workshop participants believed that their partners, and women in general, should have less education and exposure to the outside world. As a result, they often did not permit their wives to attend the project's meetings for women or to seek services at the health centers. Men in the communities also displayed a deep-seated fear of male family planning methods such as condoms and vasectomy.



Slide from the Presentation on the ReproSalud Project

### ***Further Research Questions***

Contreras and de Keijzer identified the following topics that require further research before they can be incorporated into ReproSalud's project for men:

- Develop and disseminate interventions that help men see the advantages, for them and their families, of empowering women
  - How can we communicate this effectively to men?
- Conduct more research on violence
  - What kind of dialogue do men have about the subject?
  - Can men recognize the costs of their violent actions to themselves?

- Does this type of program provide an effective form of intervention to combat violence?

Develop sustainable projects for men

- Can we link them to services?
- Aside from the testimony of participants and facilitators, how can we formally evaluate this project?
- What are the appropriate indicators?

### **Suggested Further Reading**

CISTAC (Bolivia), “Exploring Masculinities and Methodologies for Working with Men as Partners,” and Salud y Género (Mexico), “Participatory Workshops on Masculinity and Men as Partners,” in *Five Case Studies*, prepared for the Symposium on Male Participation in Sexual and Reproductive Health: New Paradigms. Oaxaca, Mexico. 1998.

“Masculinities” in *Literature Review*, prepared for the Symposium on Male Participation in Sexual and Reproductive Health: New Paradigms. Oaxaca, Mexico. 1998.

## SEXUALITY/IES

### The Social Construction of Male Sexuality

Sexuality, in some ways, is like cuisine. Every culture has a different cuisine, and nothing biological can explain our different tastes for foods. Food, therefore, is a cultural product, collectively produced and individually adapted. Sexuality is similarly constructed: there are many *sexualities*, every one has a different taste that is influenced by culture in a profound way (Parker).<sup>7</sup>

An individual's sexuality is the result of a complex joining of social, cultural, and historical processes that form a sexual identity. The existence of a hegemonic model of masculinity is one of the principal forces that shapes men's perceptions of their sexuality. Further, it has been suggested that we live in a "culture of guilt" (*cultura mortificante*), one that is based on fear and demonizes pleasure; as a result, sex is associated only with reproduction (Hernández).<sup>8</sup> The predominance of these factors has led a significant number of men and women to believe that their "natural" or biological construction is heterosexual, designed only for procreation. By equating their sexuality with an instinct, men have also come to believe that their sexual "impulse" is a force too strong to be controlled. As a result, for many men, sexual behavior is based solely on a man's will to satisfy his desire, with little concern for responsibility or the consequences of his actions (Olavarría and Valdés).<sup>9</sup> The sexual partners of these men are at great emotional and physical risk, as men are prone to use any means to satisfy their desires and affirm their manhood (Barker; Gregori; Olavarría and Valdés).<sup>10,11</sup>

The hegemonic model also influences how men interpret feminine sexuality. Many men are socialized to believe that a woman's sexual desire is born out of love for a partner, while men's sexual desire is born out of a biological instinct. This belief puts some men in a quandary when they want to have sexual relations with a woman they are not in love with. A man may think that the woman expects him to be in love with her, leading him to mislead the woman in order to achieve his goal. Furthermore, when women want to have sexual relations with partners they are not in love with, some men will view them as "easy," women with whom men should be careful (Olavarría and Valdés).

The hegemonic model of male sexuality is clearly visible when boys enter adolescence. Often, young men try to have their first sexual experience as soon as possible. They believe their manhood is confirmed by losing their virginity, knowing a lot about sex, and proving that they are not homosexual (Gregori). Many young men begin to follow

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<sup>7</sup> Richard Parker, "Masculinity, the Male Body, and Erotic Desire." Presentation.

<sup>8</sup> Juan Carlos Hernández, "Familial Construction." Presentation.

<sup>9</sup> José Olavarría and Teresa Valdés, "Studies of Masculinities in Latin America: Issues from the International Agenda." Presentation.

<sup>10</sup> Gary Barker, "Multiple Paths toward Change: Progressive Men in a Macho World." Presentation.

<sup>11</sup> Rosana Gregori, "Sexuality and Adolescent Males." Presentation.

“scripts” of sexual behavior in order to demonstrate their sexual ability and thereby affirm their identity as men. They are unaware that their desire, their eroticization of certain body parts, and their sexual activity are socially contrived. The sexual experience for these young men is not seen as an opportunity for intimacy, but rather as a goal to be achieved (Barker). In this way, the hegemonic model moves men toward relationships that may not bring satisfaction, due to the fact that they are linked to competitiveness (Gregori).

### **Male Pleasure and Male Performance**

Pleasure is an obvious and central aspect of masculine sexuality. Individuals, service providers, and researchers are often relatively comfortable discussing the role of pleasure within masculine sexuality. Statements like “he says that a condom does not feel the same” or “I think he won’t have as much pleasure if he has to withdraw before ejaculating” are common. This interest in male sexual pleasure should be appreciated; at the same time, it must be acknowledged that a commensurate interest for female sexual pleasure does not exist. Further, there is very little discussion of the other side of male sexuality: performance.

From a very young age, social constructs impact the importance that men place on performance in all aspects of life. Perhaps nowhere is performance more important to men than in the sexual arena. The widespread popularity and demand for Viagra are clear indications of this preoccupation with performance. Family planning providers, however, have failed to address the concerns of performance among men. For example, in promoting condom use, providers usually do not address the fears that a man has about losing his erection while opening the condom package and putting it on his penis. Therefore, an imbalance exists between issues of pleasure and performance within masculine sexuality: pleasure is the “open box,” which can be discussed, and performance is the “closed box,” which cannot be discussed (Rogow).<sup>12</sup>

***“Sexuality is the area in which the pressure for performance is most intensely felt.”***

***—Debbie Rogow***

### **Sexuality and Male Contraception**

The effect of the hegemonic model has led men to believe that health is an issue about which only women should be concerned. When men are in heterosexual relationships, the responsibility for sexual and reproductive health issues is often delegated to the female partner. This helps explain why men often demonstrate a contradiction between their attitudes and their practices in their use of contraception. Many men express a desire to avoid pregnancy, but place the responsibility for contraception on their partner, possibly because most available methods are female-dependent. The possible exception in this case is when men recognize a “higher-risk” situation; for example, a sexual encounter with a stranger or prostitute when men opt to use condoms as a prophylactic (Barker).

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<sup>12</sup>Debbie Rogow, “Masculine Sexuality and Use of the Condom and Withdrawal.” Presentation.

Reproductive health care professionals have also played a role in creating barriers to male use of contraception. By failing to address issues of masculinity that affect condom use, service providers have not given men a viable alternative. One prevalent contraceptive method, withdrawal, has been cast aside by many professionals who claim withdrawal is inadequate as a contraceptive, but who base their arguments on false or incomplete information. For example, medical texts and family planning literature often claim that the presence of pre-ejaculatory fluid can cause pregnancy, and hence discredit withdrawal as a contraceptive method. Recent studies have challenged this point, determining that pre-ejaculatory fluid does not contain a fertile level of sperm. Information on withdrawal as a contraceptive method is limited because withdrawal has been ignored in most studies. Furthermore, there has been minimal study on withdrawal as an STD prevention method. However, we do know that the prevalence of withdrawal is underreported, particularly among adolescents, and that many couples who do use withdrawal report very high effectiveness rates. This is not to say that withdrawal is the answer to the problems of male contraceptive use, but rather that we must address the lack of alternative methods of male contraception and better understand the attitudes of men towards family planning (Rogow).

## **Recommendations**

### **Consider the diversity of clients and their sexualities.**

Because sexualities are socially constructed, clients have different needs, concerns, and issues related to their sexual health. Professionals must consider this when providing services. It is particularly important that providers challenge homophobia within the reproductive and sexual health care service delivery system.

### **Discuss sexuality with adolescents.**

Adolescence is characterized by dramatic changes in sexual development, social relationships, and individual attitudes. Because of this, adolescents can particularly benefit from the opportunity to discuss issues of sexuality in an open, nonjudgmental atmosphere.

### **Create opportunities for men to deconstruct traditional ideas of masculinity and sexuality.**

Changing traditional perceptions of masculinity and sexuality is a slow process that cannot be carried out through a single type of effort. Sexuality education programs like ECOS in Brazil recognize this, and work with groups of men using various methodologies, such as videos, role plays, and group discussion, to challenge traditional perceptions.

### **Provide men with information about male and female reproductive health.**

Research has shown that men often lack the most fundamental information about both their own bodies and women's bodies. At the same time, men often feel that they should know a lot about sexuality and reproduction. This self-imposed expectation makes it even more difficult to ask for information. Nonthreatening spaces are needed for men to ask questions and share correct information.

### **Suggested Further Reading**

ECOS (Brazil), "Taking Male Involvement to the Workplace," prepared for the Symposium on Male Participation in Sexual and Reproductive Health: New Paradigms. Oaxaca, Mexico. 1998.

"Sexuality and Adolescent Sexuality" in *Literature Review*, prepared for the Symposium on Male Participation in Sexual and Reproductive Health: New Paradigms. Oaxaca, Mexico. 1998.

## **PREVENTION OF SEXUALLY TRANSMITTED DISEASES**

Many of the obstacles to preventing STDs/HIV among men are inseparable from men's perceptions about their masculinity and the expectations that go along with them. The fact that men who are educated about the most effective ways to prevent STDs/HIV do not always practice safer sex clearly illustrates that rational arguments are inadequate. STD/HIV prevention programs must address masculinities and male sexualities in order to be effective.

Perceptions of gender roles and inequalities are part of the challenge to STD/HIV prevention among men. Under the predominant model of masculinity, men are supposed to be strong; thus, they often feel that they are immune to STDs/HIV and do not need to protect themselves. Because women are seen as the caretakers, men tend not to believe that they can or should take care of themselves, and they often have a superficial relationship with their bodies. They may be embarrassed to expose their bodies (especially to female health care workers) or talk about sex in depth (Costa).<sup>13</sup> Men are also expected to be sexually active, and putting themselves at risk can be perceived as a way to prove their virility (Granulles).<sup>14</sup>

In order to be able to work with men on prevention, it is necessary to deconstruct some of these perceptions about masculinity and to address the misinformation they have about STDs/HIV. Through working with men in focus groups in Brazil, the Sociedade Civil Bem-Estar do Familia (BEMFAM) found that men often continue to demonstrate a lack of knowledge about STDs/HIV and how they are transmitted. For example, some men believe that they cannot get STDs from women, or that in case there is some contamination, they can fix it with a home remedy, such as washing with vinegar. This type of misinformation is sometimes propagated by the media, teachers, and even health care professionals.

Some men continue to believe in "risk groups" instead of "risky behavior." Since the hegemonic model of masculinity does not allow them to conceive of themselves as part of these supposed risk groups (e.g., homosexuals), men often do not think they are susceptible to disease (Costa). In Argentina, a study by the Fundación para Estudio e Investigación de la Mujer (FEIM) found that many adolescent males think risk is directly related to how well they know the woman, or to the type of relationship (stable vs. casual) they have with a woman (Granulles).

One of the biggest obstacles to promoting safer sex practices among men is the stigma they attach to condoms. Men tend to believe that condoms reduce sensitivity and, therefore, pleasure; that women do not like condoms; that condoms do not fit right or that they

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<sup>13</sup>Ney Costa, "Integration of HIV/STD Prevention in Family Planning." Presentation.

<sup>14</sup>Roberto Granulles et al., "Argentine Adolescents: Teen Male Experiences in STD and HIV/AIDS Prevention." Presentation.

just break anyway (Costa). Men's distrust of condoms is also linked to a need to protect their masculinity: they fear that in the moment when they have to put on the condom, it will break the mood, make them anxious, and ultimately cause them to lose their erection. The pressure to perform and the resulting fear of losing an erection are intensely felt by most men, but rarely discussed. Still, they are some of the principal factors in men's anxiety about condom use (Rogow).<sup>15</sup>

Another factor is that men do not know how to negotiate using a condom with their partners. They fear that bringing it up will not only break the mood but will also make their partners suspicious about the man's sexual fidelity. At the same time, they say women should demand that men use a condom, but that they become suspicious of a woman if she asks.

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**One of the biggest obstacles to promoting safer sex practices among men is the stigma they attach to condoms.**

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Men also demonstrate a double standard with regard to condom use. They often use condoms as a *contraceptive* measure in stable relationships, but not as a protective method. With casual sexual partners, they say they accept condom use as a way to protect themselves against STD

transmission, and they find them easier to use on these occasions. Men and women are not always aware of the triple protection condoms offer: prevention of STDs/HIV, cervical cancer and pregnancy (Group Discussion). Women do not always have the autonomy or authority in a relationship to negotiate condom use, and when men do use them, it is generally to protect themselves rather than out of any concern they have for their partner. Negotiating condom use, then, can be an expression of continuing gender inequalities in relationships.

The high cost of condoms in some countries also contributes to restricting their use. As condoms are not always widely available and affordable, especially to adolescents, it is important to give men other alternatives for STD/HIV prevention. One possible option that is already used prevalently as a contraceptive, withdrawal, is the only method that has not been included in comprehensive studies about STD/HIV transmission (Rogow).

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**Sexual and reproductive health services for men have tended to emphasize STD/HIV prevention and ignore the rest of the man.**

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Sexual and reproductive health services for men have tended to emphasize STD/HIV prevention and ignore the rest of the man. It is apparent that men do need to be taught about the proper way to use a condom. But the

difference between a man knowing how to use a condom correctly and knowing how to negotiate using a condom, both with himself and with his partner, marks the substantial difference between theory and practice.

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<sup>15</sup>Debbie Rogow, "Masculine Sexuality and Use of the Condom and Withdrawal." Presentation.

## **BEMFAM: STD/HIV Prevention through Group Work with Men**

A behavioral intervention with men for STD/HIV prevention, conducted by BEMFAM in Brazil, is an example of a project for men that begins to bridge theory and practice. Dr. Ney Costa, the executive director of BEMFAM, presented the methodology and results of this work. The project was intended to motivate men to participate in sexual and reproductive health decision making in a safe, effective, and egalitarian manner.

### ***Methodology***

BEMFAM staff developed focus groups where men could reflect on the ways in which their behavior and sexual practices are determined by culture, history, religion, and gender. Participants are encouraged to think about how they create their perceptions of masculinity and masculine roles. In the group setting, they discuss these issues and how they might interfere with the practice of safer sex. Facilitators help participants explore their feelings about condoms and seek further acceptance of their use. At the end of the workshops, participants formulate collective ideas on how to combat those characteristics that were identified as discouraging safer sex and how to prevent STDs/HIV in their own lives.

### ***Project Stages***

#### Baseline study

BEMFAM conducted a needs assessment using focus groups of men to explore questions such as: What is a man? What does he think? What does he want?

#### Program design

Based on results from the needs assessment, BEMFAM developed a model for an educational intervention for the prevention of STDs/HIV among heterosexual men.

#### Pilot test

The intervention model was piloted with small groups of men at clinics in northeastern Brazil.

BEMFAM also conducted some complementary activities in the area of information, education, and communication (IEC):

Produced educational material on STD/HIV prevention for men and couples, using such slogans as “Living and Learning” and “Speaking about Men for Men.”

Implemented a media campaign that transmitted prevention messages through television, radio, and general publicity (signs and billboards in pharmacies, train and bus stations, offices, clubs, military posts, etc.).

### ***Workshop Content***

The focus groups carried out exercises developed for the following topics:

Physical conditions related to sexual and reproductive health (cancer of the prostate and penis, premature ejaculation, erectile dysfunction)

Masculine and feminine physiology: human sexual response

Social construction of gender  
Sexual practices and behavior  
Masculinity and violence  
Sexually transmitted diseases (STDs), including HIV and AIDS  
Safer sex and condom use  
Negotiation of safer sex practices  
Safer sex between drug users  
Masculinity and reproduction

### ***Recommendations***

Dr. Costa asserted that the focus groups with men were very successful and yielded valuable recommendations for future programming.

Initial needs assessments are essential in that they bring out the issues that men *want* and *need* to resolve, thereby making interventions appropriate and client-centered.

Careful thought must go into the development of exercises and strategies to help men talk honestly in group sessions. Men tend to be less willing to talk about any kind of physical or sexual fragility, and thus tend to think of themselves as immune to diseases such as STDs/HIV.

It is helpful, at least initially, to seek out men where they congregate—in the workplace, union meetings, neighborhood clubs, etc.

Educational intervention is an important component of success in any STD/HIV prevention program. The dissemination of messages specifically designed for men in media campaigns makes an educational intervention more effective.

Male services can help sustain other programs because male clients are more likely to pay full prices for consultations.

### **Suggested Further Reading**

“STDs/HIV” in *Literature Review*, prepared for the Symposium on Male Participation in Sexual and Reproductive Health: New Paradigms. Oaxaca, Mexico. 1998.

(ECOS) Brazil, “Taking Male Involvement to the Workplace,” in *Five Case Studies*, prepared for the Symposium on Male Participation in Sexual and Reproductive Health: New Paradigms. Oaxaca, Mexico. 1998.

## VIOLENCE

The elimination of domestic violence is the latest addition to the group of issues that must be addressed in order for women to attain gender equity. Thus, there is little data available that quantifies its prevalence, defines its causes, and prescribes methods of prevention. Research on violence against women is in its initial stages. Few programs in the region address this concealed yet prevalent behavior.

***“I am not stupid. I don’t hit where it can be seen. I hit her rear end, I lift up her skirt, remove her underpants and hit her there, because she won’t show it to the police or the doctor.”***

**—from the Mexfam video  
La hora del amigo**

In order to develop a better understanding of violence in a gender context, it is important to understand some general premises about the relationship between masculinity and violence. Oswaldo Montoya presented the conclusions and recommendations agreed upon at a conference organized by FLACSO in Chile, where a small working group of 10 members from different countries tackled challenging issues related to violence and masculinity. The group concluded: “Violence has become part of masculine identity as a result of social construction and history. It is not a natural or biological condition of men” (Montoya).<sup>16</sup>

Participants proposed that a hegemonic model of masculinity has been so internalized in society that violence has become “naturalized” to the point that many men associate it with a biological impulse, an instinct similar to sexual desire (Montoya). This is played out in a variety of self-destructive male behaviors, including dangerous driving that ends in accidents, drinking competitions, and drug use. Often, these attempts to prove one’s masculinity demand more than one is able to achieve physically or mentally (Olavarría and Valdés).<sup>17</sup>

Social and historical forces have constructed a hegemonic model of masculinity that perpetuates violence against women. The model requires that men establish their authority and power, particularly within the home. Here a man often exercises his power over his partner and/or children by means of verbal, emotional, or physical violence. Research has shown that men do not need to be intoxicated or under the influence of drugs to commit violent acts (Olavarría and Valdés). Rather: “Men have become violent towards their partners as a result of their beliefs about masculine identity and how this should be reflected in the exercise of authority” (Olavarría and Valdés).

It is not only the woman who bears the negative impact of these social constructions—“Hegemonic masculinity can permit and encourage violence upon oneself and is ex-

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<sup>16</sup>Oswaldo Montoya, “The Conclusions of the Working Group on Masculinity and Violence.” Presentation.

<sup>17</sup>José Olavarría and Teresa Valdés, “Studies of Masculinities in Latin America: Issues from the International Agenda.” Presentation.

pressed in pathological characteristics of men” (Olavarría and Valdés). The working group from the FLACSO conference in Chile also recognized that “men have painful experiences, which are expressed in insecurities, fears, and emotional disconnection that must be accounted for” (Montoya). These painful experiences are often manifested in accidents, injuries, chronic disease, drug addiction, mental disturbance, and either excessive work or unemployment. Criminal behavior, another manifestation, includes homicides, robberies, and drug dealing; crimes which, for the most part, are committed by young men aged 15–25 with low to middle levels of education (Olavarría and Valdés).

**“Violence has many causes. Workshops are short, and men return to toxic lives.”**  
— **Oswaldo Montoya**

experiences, which are expressed in insecurities, fears, and emotional disconnection that must be accounted for” (Montoya). These painful experiences are often manifested in accidents, injuries, chronic disease, drug addiction, mental disturbance, and either excessive work or unemployment. Criminal behavior, another manifestation, includes homicides, robberies, and drug dealing; crimes which, for the most part, are committed by young men aged 15–25 with low to middle levels of education (Olavarría and Valdés).

The social constructions of violence have created an environment in which violence is pervasive. Today men and women face a world besieged by war, political violence, gang violence, violent crime, family violence, sexual violence, and violent media images. These forms of violence have multiple causes and cannot be linked to isolated factors; rather, power relations, domination, control, psychology, economics, and stress all contribute to this culture of macro-violence (Montoya).

**“Multiple forms of violence contribute to a culture of macro-violence”**

— **Oswaldo Montoya**

Furthermore, violence is perpetuated within environments, particularly families. When children witness violence in the family, they are more likely to repeat it themselves. Therefore, programs to address violence must look at the multitude of factors that contribute to violent behavior before designing prevention and intervention strategies (Group Discussion).

## **Emerging Issues Regarding Masculinity and Violence**

### ***Media Influence***

Our challenge to work with men on violence is a difficult one because antiviolence workshops tend to be relatively small-scale and short-term, returning men to face a toxic external environment (Montoya). That unhealthy environment is perpetuated by images in the media. Often the media use violence in a sensationalistic manner, thereby reinforcing a hegemonic model of masculine behavior. The task ahead for the mass media is not only to stop projecting negative images, but also to develop positive ones that affirm peaceful and egalitarian practices on the part of men.

### ***The Need for More Research***

Another challenge in the effort to address violence is the minimal understanding about the issue. There is very little known about violence and its relation to gender. Some participants in Oaxaca inquired whether there is a correlation between women’s emerging independence and violence against them. Initial research indicates that the hegemonic model of masculinity contributes to gender-based violence, but there are no studies that focus on this question. While there is general agreement that more research is needed, some believe that operations research that integrates research and methods to combat vio-

lence is preferable to pure research, since “the problem is so serious that we can’t wait for more studies” (Aguilar).<sup>18</sup>

### **Approaches to Working with Men**

According to the FLACSO meeting recommendations, working with men on violence requires an approach that should not “focus on blaming men, punishing them for their situation and privileges.” This kind of approach is paralyzing and does not promote change. Instead, strategies should encourage men to practice independent thinking and reflection so that they can think critically about their lifestyles. Another effective approach is discussing the issue of the costs of their own violence. Though many men may see these costs as part of the price of being macho and therefore irrelevant, some approaches based on costs may be viable. For example, the statement “if you hit your wife, they’ll put you in jail” is one basic way of helping men understand the costs of their actions. But there is a need to invite men to look beyond costs and consider instead what they could gain by being more caring and affectionate.

***“We should treat the problem with more complexity than woman-victim and man-aggressor.”***

**— Oscar Contreras**

### **Integrating Violence Prevention into Reproductive Health Services**

One programmatic strategy that may be successful in addressing gender-based violence is using reproductive health services as a means to identify victims and prevent further violence. Such an approach involves working with three groups: service providers, women as clients, and men as clients. Since women who experience violence may not seek other services or go to the authorities (police, lawyers, etc.), their use of reproductive health services might be the only opportunity to reach them. However, service providers must be trained to examine their own attitudes about violence and to develop the capacity to identify clients who are victims. There is a general consensus that nothing can be done to help these clients until providers improve their own attitudes and skills.

An unresolved issue about the involvement of service providers in domestic violence is whether they should be required to report cases of domestic violence to authorities. Experience has shown that women sometimes pay a high price—even death—if the abuser learns that the abuse has been reported, and the woman does not have a safe place to go.

Once providers are trained to address violence, it is important to convey the message to women that they can talk about violence with reproductive health care service staff. Attention-getting materials, such as posters, brochures, videos, etc., are needed in waiting rooms to demonstrate that there is counseling available on the theme of gender violence. A poster at a clinic in Brazil is an example of a direct approach; it reads: “We talk about domestic violence here.”

Men who are abusive are not likely to go to a health service—or anywhere else—to ask for help. If staff are trained correctly, counseling men on violence may be possible in a reproductive health service environment where men access services, for example, for

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<sup>18</sup>José Aguilar Gil. “The Qualitative Evaluation of *La hora del amigo*.” Presentation.

STD prevention. In order to provide messages to men about gender-based violence, strategies outside the clinic setting must be explored. Many countries are already doing this through community- and school-based education programs. (Group Discussion and Working Group on Violence)

## **Recommendations**

### **Bring men together to take a proactive stand against violence towards women.**

It is important that men take a leadership role in the struggle to end gender-based violence. During the conference, a declaration was presented that called for men to work towards creating more equitable and respectful relationships between the sexes and to end all forms of violence against women.

### **Advocate for new public legislation and policies that challenge violence.**

New laws that promote gender equality must be created. Laws must be created to penalize domestic violence, and the enforcement of these laws needs to be supported. Furthermore, patriarchal and archaic laws that legitimize and perpetuate relationship violence must be eliminated.

### **Develop and evaluate educational programs for men.**

Programs that create awareness and personal reflection on violence should be provided for groups of men. Efforts should be made to work with men in a positive manner that avoids a guilt focus. It is extremely important that such programs construct indicators to evaluate the impact of the education provided.

### **Develop systems to address gender-based violence within reproductive health care settings.**

Training for clinic staff should be provided that allows the staff to examine their personal values and attitudes related to gender-based violence and to acquire skills needed to identify and counsel victims of violence. Furthermore, institutional and legal procedures should be established to allow health care professionals to register cases of violence that they identify, with the condition that the woman is aware of and gives consent for such notification.

## **Suggested Further Reading**

Mexfam (Mexico), "Developing Educational Materials to Promote Discussion about Male Involvement," in *Five Case Studies*, prepared for the Symposium on Male Participation in Sexual and Reproductive Health: New Paradigms. Oaxaca, Mexico. 1998.

"Violence" in *Literature Review*, prepared for the Symposium on Male Participation in Sexual and Reproductive Health: New Paradigms. Oaxaca, Mexico. 1998.

# FATHERHOOD/S

What does it mean to be a father and how do men learn to become fathers?

Although there is minimal research on fatherhood, and these questions are difficult to answer, it is clear that fatherhood reflects social and cultural expectations of what it means to be a father. Initial findings indicate that both men's and women's perceptions of fatherhood are inextricably tied to, but are not the same as, their perceptions of masculinity. As in the case of masculinity/ies and sexuality/ies, there is a broad spectrum of *fatherhoods*. Models of fatherhood are products of gender relations, family relations, social relations, and economic situations.

***"We must clarify what is a good father."***

**—*María Alvarez Suárez***

Traditionally, the word paternity has been used as a legal construct, biologically linking father to child. But there are many possibilities for the nature of a relationship between father and child. There are biological fathers and adoptive fathers; there are present fathers and absent fathers, involved fathers and passive fathers, distant fathers and ideals of fathers. Furthermore, the same man can exhibit several and/or contrasting behaviors toward his children. Some examples include men who care and love the children they live with while they reject and neglect those they fathered with other women, regardless of whether they were conceived in previous marriages or in casual relationships (Working Group on Fatherhood/s).

When defined by the hegemonic model of masculinity, the father is characterized as a financial provider, an authoritarian ruler, a strong, emotionally controlled, rational being. It is clear that this definition is built mostly in opposition to a parallel and complementary paradigm of maternity: the emotional provider, the understanding listener, a soft, loving, irrational being. Thus, the question of defining fatherhood is associated with redefining gender roles and relationships. Some believe that existing models of fatherhood and motherhood must be deconstructed to arrive at healthier, more feasible relationships between father and child (Cervantes).<sup>19</sup>

### **Contrast between Hegemonic Model of Masculinity and New Paradigms of Fatherhood**

<b>Old Paradigm: Masculinity</b>	<b>New Paradigm: Fatherhood</b>
Primary and sole financial provider	Shares financial-provider role with partner
Authoritarian disciplinarian	Supportive and understanding of his children's emotional and educational needs
Unemotional, distant, restrained	Emotional, present, involved in all aspects of childrearing

<sup>19</sup>Francisco Cervantes Islas, "Paternity as a Process of Reflection and Change within Men." Presentation.

The most obvious, though certainly not the only, way a man can take on the responsibilities of parenting is through the decision when and if to have a child. Until recently, in many cultures men and women shared a concern about preventing pregnancy because of the social requirement that a man marry a woman who is pregnant with his child. In the past three decades, however, social and generational changes and the prevalence of contraceptive methods that are female dependent have reduced this expectation, with the result that regulation of fertility has become primarily a female priority (Rogow).<sup>20</sup>

The threat of financial responsibility continues to be a prominent factor for males in deciding whether or not to use contraceptive methods. A recent study showed that, among adolescents, the desire to avoid getting a woman pregnant is motivated primarily by the desire to avoid financial responsibility. Even though the men said they wanted to avoid pregnancy, they continued to place the responsibility for contraception on women. Thus, the decision to not become a father is often a decision made by women. We now also know that the hegemonic model presents a double standard about contraception that corresponds to two perceived “types” of women: one who is “easy” and associated with pleasure, and another who is associated with marriage and motherhood (Working Group on Fatherhood/s). It has been observed that men who have casual sex often do not try to protect against pregnancy because they do not respect the woman or think of her as a possible mother. (Nevertheless, they occasionally use condoms with these women to protect themselves from sexually transmitted infections). As a result, men often do not take responsibility (financial or otherwise) for children who are products of casual relationships, though they may boast of the existence of these children as evidence of their “masculinity.” With women they see as possible wives and/or mothers, men usually assume more responsibility for contraception and the decision to have children (Working Group on Fatherhood/s).

In almost every culture, fathers are supposed to be providers. A failure to provide, or the inability to be the primary provider for the family, can be a source of humiliation and a perceived loss of points on the “macho meter” (de Keijzer).<sup>21</sup> It can also be a source of violence and/or abandonment, as the father struggles to express his frustration at not being able to meet the expectations placed on him. If they are the principal financial providers, fathers have an enormous amount of power over their children and decision making within the family. “Wait until your father comes home,” is a common response of mothers who have internalized gender roles that delegate decision making and punishment to the father figure.

***“The role of the father has traditionally been that of the person who imposes order, who imposes the law of the father, who imposes seriousness in the home.”***

**— Juan Carlos Hernández**

Fathers who conform to a hegemonic model of fatherhood tend to be authoritarian, handing down decisions without asking for opinions from members of the household who will be affected by those decisions. They misunderstand or deny the sexuality of their chil-

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<sup>20</sup>Debbie Rogow, “Masculine Sexuality and Use of the Condom and Withdrawal.” Presentation.

<sup>21</sup>Oscar Contreras and Benno de Keijzer, “ReproSalud and Manuela Ramos: A Collaborative Project.” Presentation.

dren, and are intolerant when the children express their sexuality. They are the disciplinarians of the family and carry out the function of policing behavior and punishing transgression (Hernández).<sup>22</sup>

Furthermore, fathers are restricted in expressing their own emotions because they think they are expected to be rational and restrained. Thus, their presence in the family is limited to a serious reserve that denies them the possibility of being affectionate with their children. As a result, fathers often cannot enjoy fatherhood. In the process of regulating the pleasure of children, they succeed in eliminating their own pleasure (Hernández). Studies show that fathers exhibit a high level of pain and stress due to familial problems, and therefore tend to seek pleasure outside the family sphere (Hernández).

***“Fathers have the right to happiness in the home.”***  
**— Juan Carlos Hernández**

A new paradigm of fatherhood would mean the possibility of rescuing joy for fathers, giving fathers the right to happiness in their relationships with their children (Hernández). Focus groups with men have shown that men do want to be more actively involved in their children’s lives and education (Costa).<sup>23</sup> But this would necessitate de-emphasizing a father’s role as a provider, allowing him the space to be more emotionally involved and physically present in his children’s lives.

The construction of a new paradigm of fatherhood is inhibited by the persistence of old models of masculinity that are in direct opposition to more integral models of fatherhood. When men are given paternity leave, for example, it is very difficult for them to take this time off because the social pressures to work and earn money are too strong (Cervantes).<sup>24</sup> Furthermore, legal convention continues to reinforce the father-provider paradigm by expecting men to pay child support and by assuming that primary custody should be granted to the mother.

Developing alternative models of fatherhood requires working with women who may interfere with or impede fathers’ relationships with their children. Traditional paradigms of fatherhood and masculinity emphasize a single construction of a family: Father-Mother-Child(ren). The roles of parenting in this model are neatly divided between genders, without any crossovers. Deconstructing these rigid gender roles would create the possibility for other familial structures that are not necessarily based on biology: Father-Child, Mother-Child, Father-Father-Child, Mother-Mother-Child, etc. (Group Discussion).

Within the familial structure of Father-Mother-Child(ren), there are possibilities for new models of fatherhood. A new paradigm of fatherhood could incorporate a democratization of family life, wherein the father is less of an authoritarian figure and allows other family members the right to be part of the process of making decisions that affect them. It could also mean that the father stops being the regulator of sex and pleasure in the family, recognizing equal rights to pleasure without regard to age, gender, or sexual orientation (Hernández).

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<sup>22</sup>Juan Carlos Hernández, “Familial Construction.” Presentation.

<sup>23</sup>Ney Costa, “Integration of HIV/STD Prevention in Family Planning.” Presentation.

<sup>24</sup>Francisco Cervantes Islas, “Paternity as a Process of Reflection and Change within Men.” Presentation.

Research and program experience indicate that adolescent males are more open to a new paradigm of fatherhood. Many have very negative images of their fathers and express a desire to be different fathers themselves. When they get married, however, they often revert to the hegemonic model that society expects (Hernández). There is tremendous societal and peer pressure, especially on adolescents, to fit into the mold of hegemonic masculinity and fatherhood.

Other research suggests that the way men play out their role as fathers changes throughout their life cycles. As they get older, they often become more outwardly affectionate and less authoritarian. The care and tenderness grandfathers often express with their grandchildren indicates that men's conceptions of fatherhood (and masculinity) become less rigid with age. These alternative models might provide a guide for new paradigms of fatherhood.

### **Maternidade Leila Diniz: Involving Men in Pregnancy and Childbirth**

The Maternidade Leila Diniz is a birthing center that seeks to involve expectant fathers in the process of pregnancy and childbirth, thereby fostering a stronger connection between fathers and children. Dr. Katia Ratto presented the development and results of this program (Ratto).<sup>25</sup>

The Program of Integral Assistance for Women (PAISM) was founded in 1983 as a result of lobbying by powerful and militant feminists in the Ministry of Health in Brazil to promote national policy to improve women's health and reduce maternal mortality. Brazilian culture has always defined birth as a medical and not a natural event; thus the environment in birthing wards in hospitals is generally one of surgeries and anesthesia, completely lacking in human warmth and emotional support for mothers. Studies conducted over the last 30 years have revealed that, in overmedicalizing the birth process, hospitals have partially excluded mothers and, to a greater extent, fathers from participating in childbirth.

Maternidade Leila Diniz was founded as a birthing center with the objective of rehumanizing the process of childbirth for mothers. Leila Diniz trains midwives and any individual(s) whose presence is requested by the expectant mother (father, relatives, friends) to accompany her in childbirth as a "birth partner." (One study in China demonstrated that teaching fetal monitoring to both expectant parents led to decreased fetal deaths: perinatal deaths = 6.3/1000 live births in the test group versus 10.9/1000 in the control group).

In joining the Maternidade Leila Diniz, each health care professional must go through a six-month training in order to learn about and accept the many ways in which the center makes expectant mothers and birth partners feel more comfortable (domestic setting, vertical birthing chair, ample space and role for birth partner). Maternidade Leila Diniz encourages fathers to participate with expectant mothers in all prenatal, interpartum and postpartum visits. Birthing groups are conducted with both expectant mothers and their birth partners, thereby training both individuals for their roles in childbirth.

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<sup>25</sup> Katia Ratto, "Male Participation during Pregnancy and Birth." Presentation.

## ***Evaluation***

In 1996, the Leila Diniz staff conducted an evaluation of their program. Initially there had been some antagonism on the part of the health care providers about the presence of another party, the birth partner, in the birthing room. The center's staff wanted to evaluate the impact of the training given to all newly hired providers on the importance of the role of the birth partner. The results were quite promising. In 50% of the births, an untrained birth partner was present. Half of those birth partners were expectant fathers and the other half were mothers, friends, or other relatives. The evaluation revealed that there was no conflict between the birth partner and the health care provider delivering the child. The attending doctors and/or midwives demonstrated acceptance and approval of the partner's presence. The evaluation also demonstrated that the expectant father needs support during prenatal, interpartum, and postpartum phases.

## **Recommendations**

### **Address models of masculinity that negatively influence a man's role as father.**

As long as men are expected to be rational at the expense of emotions, and superior at the expense of sharing responsibilities of childrearing, it will be difficult for them to discover new models of fatherhood. Men should be encouraged to examine how their perceptions of masculinity might interfere with their relationship with their children.

### **Involve women in redefining fatherhood.**

Often, both male and female gender roles inhibit fathers' emotional involvement in their children's lives. Working with men *and* women is necessary in order to arrive at a more egalitarian model of parenting.

### **Involve men in all phases of pregnancy and the birthing process.**

The fact that expectant fathers do not experience the growth of the child within themselves can stimulate the desire for alternative proof of their productivity via increased workload and capacities as the provider. Involving men in pregnancy and childbirth can help minimize the distance frequently felt by fathers after the birth of their child(ren).

### **Accept fatherhood as something more than a legal and biological construct.**

Fathers need to be recognized in terms of their relationship with children, not just in terms of their legal responsibilities or a biological connection.

## **Suggested Further Readings**

"Fatherhood" in *Literature Review*, prepared for the Symposium on Male Participation in Sexual and Reproductive Health: New Paradigms. Oaxaca, Mexico. 1998.

CISTAC (Bolivia), "Exploring Masculinities and Methodologies for Working with Men as Partners," and Salud y Genero (Mexico), "Participatory Workshops on Masculinity and Men as Partners," in *Five Case Studies*, prepared for the Symposium on Male Participation in Sexual and Reproductive Health: New Paradigms. Oaxaca, Mexico. 1998.

## COUNTRY ACTION PLANS

During the final day of the symposium, participants were divided into small working groups by country in order to develop recommendations for action plans in their respective countries. The purpose of this activity was to give participants the opportunity to discuss the themes and lessons learned during the symposium and to relate them to their national contexts, needs, and priorities.

### **Example of Country Team Recommendations for Action Plans**

The Colombia country team provides a good example of the kinds of recommendations that can result from this effort. The team was made up of seven participants representing the public, private, and NGO sectors. Prior to the October event, team members met to review the themes and objectives of the symposium as well as to discuss priorities within their own agencies and organizations. Once at the symposium, team members developed their discussion according to the following three points: (1) prioritization of areas for work in Colombia; (2) actions and mechanisms to allow for a concerted effort of work in the area of sexual and reproductive health; and, (3) creation of mechanisms for follow-up and dissemination of results from these efforts. Some of the resulting recommendations include the following:

#### ***Priority Areas for Work in the Area of Sexual and Reproductive Health***

Include a gender perspective as an integral part of health services offered in Colombia in terms of quality of care, follow-up, and evaluation.

Strengthen policies to increase men and women's access to family planning services

Train administrators and researchers in resources management to strengthen sexual and reproductive health programs.

Develop sexual and reproductive health services for men.

Develop communication strategies regarding the sexual and reproductive rights of men and women.

#### ***Actions and Mechanisms for Program Implementation***

Review analytically the newly formed social security system, the Plan Obligatorio de Salud (POS) (mandatory health plan), the Plan de Atención Básica (PAB) (basic health plan) and its policies for sexual and reproductive health.

Analyze the terms of reference used by public and private entities in establishing research contracts with universities or NGOs.

Analyze the evaluation mechanisms for the quality of the health services provided.

Analyze the possible resources available via the FOSYGA (taxes on arms and explosives) as a funding source to support the development of actions, programs, and research on domestic violence.

Analyze the curricular content in health and social science courses offered by universities in terms of their inclusion of key concepts, such as gender and sexual and reproductive health.

Design strategies to link the adolescent population to sexual and reproductive health programs in Colombia.

Design programs to increase male participation in sexual and reproductive health.

### ***Mechanisms for Follow-Up and Dissemination***

Plan monthly meetings with representatives of Colombian institutions represented in Oaxaca, as well as those organizations that are interested in masculinity and sexual and reproductive health, to review proposals and assess progress in implementing programs for men.

Design communication strategies for any initiatives resulting from the symposium that seek to link men with sexual and reproductive health.

The country team proposed to raise awareness about the themes discussed at the symposium through a weekly radio program. The program entitled “Everyone” will be broadcast by the radio station at the National University of Colombia (U.N. Radio) every Sunday at 9:30 am. The team is also exploring other possibilities through commercial and public radio.

Continue conversations with the Ministry of Communications in order to expand the sphere of these broadcasts.

Agree on current priorities of sexual and reproductive health and identification of the organizations committed to service provision, policy design, and research development.

Explore and design strategies that link universities and NGOs with public sector entities to encourage collaboration in designing and implementing services and policies.

Develop an inter-institutional and inter-sectoral communication network.

The team proposed that organizations participating in this network be linked to the monthly meetings conducted by the Gender, Women and Development Program of the Center for Social Sciences at the National University of Colombia, as well as with other Latin American groups, institutions, and organizations working on these issues.

Analyze and review the Colombian legal framework, with emphasis on those aspects that imply gender equity, male participation, quality of care, and others, with the objective of enriching the political dialogue and knowledge of the themes, activities, and actions that are taking place in this field.

### **Additional Country Team Recommendations**

The different country groups made additional recommendations for further action in the areas of research, communications, programs, and services.

### ***Research***

Create a country-specific database on men and reproductive health (Bolivia).

Elaborate a text with information from the annotated bibliography (Bolivia).

Conduct collaborative research projects to promote exchange of information between agencies/countries (Mexico).

Incorporate research by established programs (e.g., Mexican Social Security Institute (IMSS), National Commission on Population (CONAPO), etc.).

Optimize on Mexico's role as a pioneer country and address chasm between research and action, researchers and service providers.

Conduct a national assessment to determine course of actions for services (Mexico).

Exchange baseline data regarding the status of male involvement and major health indicators between countries (Central America).

Consider indigenous and ethnic groups in the analysis of data (Central America).

Conduct a national assessment study re: men and their reproductive health (Paraguay).

Publish a background document re: general conditions for research on men and reproductive health (Paraguay).

Hold a *convocatoria* (Request for Proposals) where the research profile can be established (Paraguay).

Develop indicators that take into account male participation (Central America).

### ***Communications***

Organize a press conference to discuss the Oaxaca workshop and support the Campaign Against Violence Toward Women (Bolivia).

Organize a half-day event to educate multi-sectoral decision makers at the national level about the Oaxaca workshop (Bolivia).

Include leaders from the feminist movement and collaborate with them on projects given their existing networks (Brazil).

Have a meeting June 1999 with multi-sector agency representatives, psychologists, and others working in this area to define future strategies for Brazil.

Create a website as a way of maintaining interest, contact, and sharing of materials.

Create informal spaces for interaction (*encuentro en pasillo*) (Mexico).

Seek representation and involvement by rural and indigenous populations of countries involved (Mexico).

Create a multi-sector network (Brazil and Mexico).

Promote public and private sector institutional collaboration (Brazil and Paraguay).

### ***Programs and Services***

Create an interagency committee to lead, plan, and coordinate activities related to masculinities (Bolivia).

Complete the design for a plan of action (Bolivia).

Identify needs and demands re: masculinities and match these with donor strategies (Bolivia).

Design a curriculum and methodologies for gender training that are adaptable to the characteristics of target institutions and populations (Bolivia).

Facilitate exchanges with other organizations (Brazil).

Create a mini-training program on masculinities to form regional resources (Regional Working Group).

Use Oaxaca workshop as a springboard for additional in-country work on related themes or issues (Brazil, Mexico, and Paraguay).

Form working groups, by country, to narrow the gap between research and programs (Regional Working Group).

Create a national committee and have an initial follow-up meeting to establish a mechanism and set forth a national agenda (Mexico).

Establish stronger collaboration between Government and NGOs (Brazil and Mexico).

Capitalize on the richness of experiences throughout the region—emulate and adapt examples of successful programs (Mexico).

## RECOMMENDATIONS

Research and programmatic experience presented at the symposium noted that clinical services are not sufficient to satisfy men's sexual and reproductive health needs. Programs for men must also address each man's perceptions of his masculinity, helping him identify how he arrived at his model and how it influences his behavior with regard to sexuality, violence, STD/HIV prevention, and fatherhood. This kind of interdisciplinary approach to services requires further research into religious, political, regional, national, and cultural influences on gender identity and decision making in sexual and reproductive health. Service providers should conduct a baseline study of the specific needs and desires of the men they hope to reach with their services by talking with both men and women. An evaluation of existing financial and human resources for responding to the needs that emerge might reveal underused resources that could be devoted to expanding a program to serve men. Such an evaluation of resources could also help to define program priorities and short- and medium-term objectives. Symposium participants also agreed that service providers can be agents of change by sharing information and exemplifying the values and behaviors required to negotiate and make decisions, whether on an individual basis or between couples.

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**One overarching recommendation that generated universal consensus is that information on all aspects of sexual and reproductive health, including STD/HIV prevention, should be directed to both men and women.**

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Participants noted many points that service providers should keep in mind when developing programs for men. One overarching recommendation that generated universal consensus is that information on all aspects of sexual and reproductive health, including STD/HIV prevention, should be directed to both men and women.

### **Institutional Changes and Staff Training**

#### **Create awareness about how men's involvement in sexual and reproductive health benefits women.**

Some reproductive health care professionals believe that attempting to create services for men will use up scarce resources needed for serving women. While it is imperative to safeguard existing services for women, neglecting men and their reproductive health will bring adverse consequences for both sexes. Women have asserted (most notably at the ICPD conference in 1994 and Beijing in 1995) that involving men in reproductive health services is necessary to achieve gender equity and to alleviate many of the problems that weigh more heavily on women—men's involvement will reduce the incidence of violence, STDs/HIV, and unplanned pregnancies.

#### **Sensitize service providers regarding men's reservations about sexual and reproductive health services.**

Men often have anxieties caused by social forces and traditions that are in opposition to the use of family planning, just as women did when they were approaching these clinics for the first time. Men will need the same support as women to overcome what they have learned and seek reproductive health services.

**Build new rules and relationships among staff that offer alternative gender models.**

Staff must be comfortable with progressive models of masculinity and femininity, and they should be role models for each other and their clients.

**Conduct values clarification work with providers to help them understand their own biases about certain clients.**

Participants acknowledged that clinic staff tend to have negative attitudes about working with adolescents and that, in some cases, they question men's presence in clinics. Service providers should be receptive, respectful, and responsive to all clients, whether they are men, women, or adolescents.

**Change the image of health institutions as "female spaces."**

Men may be reluctant to visit sexual and reproductive health clinics because they think of them as places for women. The environment in clinics must be appropriate and welcoming for both sexes.

**Identify emerging issues.**

Analyze the results of academic studies in order to apply findings to service delivery settings. There may be many ideas for programming embedded in existing research results.

## **Program Design**

**Develop integrated health services for men.**

Providing only vasectomy and STD/HIV prevention services is usually not adequate to address men's sexual and reproductive health needs. Services should develop strategies that acknowledge the obstacles to men's involvement in their sexual and reproductive health and in that of their partners, and should offer men a holistic approach to understanding and acting upon their myriad needs in a way that also respects women's needs.

**Seek men where they congregate.**

Sometimes, especially when a program is just beginning, it is most effective to reach men in places outside the clinic, such as in the workplace or at union meetings.

**Provide men with a private space for reflection.**

Participants agreed that it was important to work with organizations and in places where men congregate (e.g., fathers' clubs, community groups, sporting events, workplace events) and to train staff to work with men and offer them a private space to reflect on their own models of masculinity. Writing autobiographies, diaries, or directed life stories are just some examples of ways in which men can begin to reflect on their perceptions of masculinity and question all behavioral norms prescribed by the hegemonic model of masculinity.

**Facilitate group work with men.**

Several programs (e.g., BEMFAM, ReproSalud) show that working with men in a small, nonthreatening group setting is effective. Men are more likely to express alternative values and talk about their fears and pressures in a secure environment, free of criticism. They can also begin to devise collective solutions to these issues and become role models for progressive life styles in their communities.

**Design services that attract men without reinforcing the hegemonic model of masculinity.**

Attracting men to services by promoting characteristics, such as virility and omnipotence, that are associated with the hegemonic model is likely to strengthen this model. Services should instead appeal to the side of men that is often most difficult for them to express: their emotions, fragility, uncertainties, and fears.

**Encourage women to invite their partners to health services.**

While men may be hesitant about seeking sexual and reproductive health services, their partners might be influential in convincing them to do so. Programs that treat couples might provide men with their first opportunity to care for their own health. Providers should encourage and be receptive to men's *constructive* involvement in sexual and reproductive health, while giving women's decisions a priority.

***“Profamilia supports the woman’s decision if there is a conflict between a couple.”***

**— Maria Isabel Plata**

**Include adolescent males in the design and development of programs.**

Adolescents are often more open to change than adults, but they need to be exposed to alternative models of masculinity. Just like adult men, adolescent males need a nonthreatening group space where they can express their feelings with peers. One way to provide this space is for adolescents to be involved in the design and management of programs. Some have found peer mentoring to be an important mechanism, for example.

- **Promote collaborative efforts.**

Linking with governments, NGOs, and community organizations to create and implement programs enables such networks to pool resources, avoid duplication and reach a wider audience. Collaborating on evaluation with organizations that have experience in working with men and may have tools to share would assist in the documentation of impact.

## **Evaluation**

**Explore the quantitative data that already exist (on pregnancy, cervical cancer, etc.) and their implications for measuring male involvement and the potential benefits for women and children.**

Many women are asking service providers to involve men, because they are convinced this strategy will help reduce maternal mortality and improve maternal and child health. These beliefs must be supported by tracking appropriate indicators in order to craft a compelling argument for policymakers, donors, and other audiences.

**Design and combine quantitative and qualitative research methodologies that measure the impact of programs that involve men in women’s and men’s sexual**

**and reproductive health, as well as the impact of such programs on gender equity.**

### **IEC Campaigns and Public Policy**

#### **Design campaigns and educational materials that specifically target men.**

Materials should include messages of concern to men and be available to men in the places where they congregate: military posts, bus and train stations, male bathrooms, bars, offices, factories, etc. Content should not promote dominant stereotypes of gender roles.

#### **Incorporate men into *all* aspects of sexual and reproductive health campaigns.**

Men should be involved in the design, implementation, and evaluation of IEC campaigns, including those that are often considered to be “women’s” issues, like maternal mortality and cervical cancer.

#### **Raise public awareness of men’s reproductive health issues.**

Many of the issues that men need to address in sexual and reproductive health have been considered taboo. Bringing issues like performance, impotence, and fear of losing an erection into the public sphere of discussion can help men come to terms with these issues.

#### **Introduce, support, and strengthen legislation that promotes gender equity.**

Service providers should promote laws against domestic violence, and they should spread knowledge of these laws and punishments. In some cases, it is also necessary to work to annul patriarchal and archaic laws that legitimize and perpetuate domestic violence (e.g., in Nicaragua, where adultery is penalized when committed by a woman but not by a man).

## CONCLUSION

In a world in which “man is a synonym for humanity,” involving men in sexual and reproductive health also requires addressing historical, cultural, religious, and economic paradigms that are male centered (Figueroa). Clearly, historical and social forces play an important role in promoting the idea that men are inherently violent, when research indicates that men are not born violent but become so to conform to the hegemonic construct of masculinity (Montoya).

The implications and repercussions of changing accepted norms in behavior, attitudes, strategies, and even language used among professionals and with clients, permeated all aspects of the symposium. Dr. Sanhueza summarized some of the myths that must be challenged to build a gender-equitable world:

It’s easy to accept social norms. It’s dangerous to depart from firmly established norms...to accept that men cry, are doubtful and fearful...as well as tender and affectionate...behaviors they have difficulty showing.

As fathers become more comfortable in sharing parenting, mothers have to give them space to be with their children. Employers have to provide more flexibility to workers so they can carry out family responsibilities. Messages about contraception and children should be directed toward both men and women (Working Group on Fatherhood and Working Group on Conceiving Programs for Men).

The discussions held among a hundred participants for four days only scratched the surface of understanding masculinities, sexualities, violence, and fatherhood. This was true in spite of the fact that a number of participants were familiar with the deliberations of two previous conferences in the region that focused on the same topics. Since the objective of this meeting was to move from research to action, participants faced the challenge of implementing programs that incorporate preliminary research results and innovative ideas that lack evaluation. They also agreed that program implementation requires determining the information required to work effectively and defining the appropriate criteria to conduct meaningful assessments.

Presentations and informal discussions underlined the absence of research on domestic violence and fatherhood as well as the dearth of programs that address these topics. Thus, participants concluded that there is a pressing need for studies and mechanisms to reduce gender violence and to work with men and women to facilitate more equitable sharing of family planning and parenting responsibilities.

Participants also became acutely aware of the complexity of masculinities and sexualities as these were discussed in great detail. The intricacies within each theme involve offering alternatives to long-established behavioral scripts. Since it is during adolescence that people form their identities, including their sexuality, participants agreed that working with adolescents is essential. They also recognized that the issues addressed in separate panels are interlinked.

The country action plans reflect a general agreement on the necessary initial steps toward program implementation: further discussion and more research and concerted efforts to cross traditional boundaries by reaching out to collaborate with new partners. The majority of the country plans include intentions to hold countrywide meetings to discuss themes presented at the symposium that are of particular interest to a given country and to consider program priorities within each country.

In addition, participants became keenly aware of norms they readily accept, but need to question in their daily lives, as professionals, as men, women, husbands, wives, mothers, fathers, sisters, and brothers—as individuals, in their daily routines. Dr. Pollack gave the following example:

When I find myself next to women dying in labor, dying because of lack of care or the impossibility of arriving at the hospital on time, I see a man in pain, because he may have been a barrier. Either because he couldn't get her to the hospital quickly, or he didn't support her use of contraceptives, or he himself did not have access to family planning to prevent this labor, the one that takes her life.

The lessons learned by each participant, the energy, motivation, dedication to gender equity, enthusiasm, and optimism about the work that lies ahead, and the tears and laughter shared during these four days cannot be adequately captured in this summary.

## **Appendix A**

### **Abstracts of Presentations**

#### **Panel 1: Masculinities**

**Richard Parker, Columbia University, USA. “Masculinity, the Male Body, and Erotic Desire.”**

One of the biggest challenges for sexual and reproductive health care service providers is a movement from a biomedical vision to a more sociocultural vision that incorporates ideas about gender, sexuality, and masculinity into their programs. Sexuality is a social, cultural, political, and economic construct that not only reflects society, but also produces society. Sexuality can be compared to cuisine: every culture has its own tastes and practices that cannot be explained biologically; rather, they are created collectively and adapted individually. Desire and the parts of the body which are eroticized are also sociocultural constructs, as are sexual scripts that are internalized and then assumed to be universal. Sexual and reproductive health care service providers must reevaluate their services, taking into account the social and cultural constructions of sexuality.

**José Olavarría and Teresa Valdés, FLACSO, Chile. “Studies of Masculinities in Latin America: Issues from the International Agenda.”**

This paper provided an historical and theoretical synopsis of current knowledge of masculinity. The paper included a definition of the hegemonic model of masculinity and concludes that this is a painful and costly model for men to try to emulate. Most men cannot live up to it—there are “masculinities.” Nevertheless, many of the principles in the normative model hinder men from adopting behaviors required in a world where women are diversifying their roles. Since masculinity is defined in direct opposition to femininity, as women’s responsibilities in the workplace, the community, and the home change, so must men’s.

**Juan Guillermo Figueroa Perea, Colegio de México, Mexico. Commentator.**

In his commentary, Figueroa reflects on how masculinity is interpreted when it is related to sexual and reproductive health. He proposes the need to systematize the studies done on men, and mentions the need to focus on new paradigms and gender perspectives. He identifies five models for the interpretation of masculinity: Demonized; victimized; autoflagellated; socially conditioned but paralyzing because of its complexity; and socially conditioned but recognizing possible changes throughout its history. The latter model is the most promising, for it not only allows us to identify sexism in practice, but also in the norms reproduced by different social acts as well as the institutions with whom they are permanently related. In his opinion, sexual and reproductive health is based in multiple relations of power: Power that shapes encounters between genders, and power that legitimizes some disciplines and appoints institutions to address these issues.

## **Panel 2: Masculine Sexuality: Youth**

### **Rosanna Gregori, ECOS, Brazil. “Sexuality and Adolescent Males.”**

Workshops conducted by Estudios y Comunicación en Sexualidad y Reproducción (ECOS) gave adolescent males a space to discuss their questions about sex and sexuality. These workshops became a springboard for deconstructing models of masculinity, gender roles, and sexuality. They found that adolescent males’ sexuality is a product of their model of masculinity, incorporating ideals of conquest, superiority, heterosexuality, and the need to be more experienced than women in sex. It was also found that adolescent males demonstrate a lack of knowledge about sex, sexuality, and reproduction. They tended to equate sex with sexuality and demonstrated an attitude of omnipotence and distrust. When they began to feel more comfortable in the workshops, they expressed doubts and concerns about sex, STDs/HIV/AIDS, pregnancy, and contraception. In their relationship with their bodies, they tended to overvalue the penis. An intense homophobia kept them from expressing affection physically or even looking at the bodies of their peers. When provided with a relaxed, nonthreatening atmosphere, adolescent males are very interested in discussing issues of sex and sexuality, even if they are shy about it in the beginning. Adolescents respect direct and clear language, and need programs that will address their sexuality and feelings as well as STD/HIV prevention and contraception.

### **Gary Barker, Chapin Hall Center for Children, USA. “Multiple Paths toward Change: Progressive Men in a Macho World.”**

The intent of Barker’s paper was to present various possibilities for educators, activists, and service providers to work with men in convincing them to adopt more progressive attitudes and behaviors. After defining the characteristics of a progressive male and reviewing theories of male development, including male identity in infancy and adolescence, Barker challenged some of these theories. He suggested alternative ways through which males can hold on to behaviors they exhibit as children that foster the evolution of progressive men.

Barker cited results of qualitative studies done with adolescents who are asked to define their views of masculinity, reproductive health, pregnancy, attitudes toward women, and gender violence. He used the results of these studies to underline that within each focus group he found one or two progressive male adolescents. Baker defined the experiences that lead these young men to challenge the hegemonic model of masculinity and adopt alternative behaviors. He suggested that these situations provide important clues about how to foster progressive males.

## **Panel 3: STDs/HIV/AIDS**

### **Ney Costa, BEMFAM, Brazil. “Integration of HIV/STD Prevention in Family Planning.”**

Based on past experiences BEMFAM has in this area, Ney Costa presented a framework for integrating prevention into family planning services. He found that the integration strategies had positive effects on the overall quality of service at the clinics, and produced concrete changes in behaviors and capabilities of BEMFAM personnel.

Some initial obstacles included the stigma against STD services, a reduced amount of resources for family planning services, resistance to talking about sexuality, and the resistance of men to participating with their partners. He suggested the following points to overcome these obstacles: compile and spread information about STDs/HIV in Brazil as reference material; discuss the vulnerability of women and adolescents; conduct sensitization activities; and develop an institutional commitment to integration.

#### *Intervention Project with Men*

BEMFAM actively promoted the participation of men in sexual and reproductive health services provided by its clinics by offering new services specific to men's needs. An STD/HIV prevention effort with men was carried out through all-male focus groups. In the sessions, men were encouraged to reflect on the sociocultural determinants of their behavior, to discuss the issues that interfere with their practice of safer sex, and to try to define collective solutions that would lead to a more widespread acceptance of condom use. Men expressed their acceptance of the use of condoms as a contraceptive in stable relationships and as an STD/HIV prevention measure in casual sexual relationships. Some obstacles to the practice of safer sex among men were the following: a feeling of strength and immunity, the perception that condoms reduce sensitivity and pleasure, the fear of losing an erection, the belief in risk groups (as opposed to risky behavior), the high cost of condoms, and the insecurity about negotiating condom use with a partner. Giving men a space (apart from sexual and reproductive health clinics) to talk with other men about their sexuality, values, myths, and preconceptions is essential to working with them on prevention.

#### **Roberto Granulles (with Mabel Bianco, María Inés Re, and Laura Pagani), FEIM, Argentina. "Argentine Adolescents: Teen Male Experiences in STD and HIV/AIDS Prevention."**

Through working with adolescents in Buenos Aires on HIV/STD prevention, the Fundación para Estudio e Investigación de la Mujer (FEIM) discovered that young men need a space where they can talk about their fears and difficulties in relating to women and in identifying with the *machista* paradigm. According to this paradigm, men are expected to be more sexually active and experienced than women, which leads many adolescent males to initiate sexual relations, often with prostitutes, at an earlier age than their female peers. They feel that they must always be prepared to have sex or engage in risky behavior in order to prove their virility. Further, the paradigm teaches adolescent males not to show their emotions, needs, or feelings. These internalized characteristics are evident in focus group work. As knowledge about STDs/HIV does not necessarily mean that people will practice safer sex, it is apparent that any strategy for working on prevention must include more than rational arguments about protection. Strategies for men must also take into account factors that are related to paradigms of masculinities. For example, for a man to protect himself, he must first be able to perceive himself as vulnerable and as a caretaker, qualities that he may associate only with women. Training peer educators to work with youth and training adults about sexuality and prevention are important for prevention programs for adolescents.

#### **Panel 4: Masculine Sexuality: Programmatic Strategies**

##### **Debbie Rogow, USA. “Masculine Sexuality and Use of the Condom and Withdrawal.”**

Historically, academics, service providers, and individuals have emphasized the concept of pleasure within masculine sexuality. However, we tend to ignore the importance of performance within that same sexuality. This imbalance has tremendously distorted the ways in which we research, offer, and discuss such male methods of contraception as the condom and withdrawal. This focus on masculine pleasure has caused us to discount and misrepresent such methods as the condom and withdrawal, the latter of which is more prevalent and effective than the majority believe. In order to expand the range of options offered to clients and to respond to the needs of such populations as adolescents who are already using these methods, we are obliged to provide the correct and documented information about them. We must also start to research male methods with a special focus on the role of pleasure *and* performance in masculine sexuality.

##### **Oscar Contreras, ReproSalud, Perú, and Benno de Keijzer, Salud y Género, México. “ReproSalud and Manuela Ramos: A Collaborative Project.”**

During ReproSalud and Manuela Ramos’ collaborative project to improve the reproductive health of women in rural and suburban Peru, the female participants assessed their own health needs and priorities. One of the priorities assessed was the need to involve their husbands in the project. ReproSalud piloted a series of workshops in order to work with men on the following five major topics: (1) the male role in power relations, (2) male participation and responsibility in reproductive health, (3) knowledge of the body and its care in reproductive health, (4) male violence and sexual and reproductive rights, and (5) the advantages from a change in gender relations. The workshops trained peer educators who replicated the activities they learned with other men in the community. Challenges included the predominance of sexist male attitudes towards women and a fear of condoms and vasectomy. Opportunities included the male desire to learn, support for contraception, and a willingness to participate in a project run by community women.

##### **Maria Isabel Plata, Profamilia, Colombia. “Programs for Men: The Experience of Profamilia-Colombia.”**

In following the model of PROPATER in Brazil, Profamilia has recently expanded the range of its services to include services for adolescent men. The services offered include urology, infertility, sexual therapy, general medicine, laboratory tests, outpatient surgery, STD treatment, and family planning. Plata emphasized the importance of ongoing evaluation of services to reassess perspectives and assumptions and assure quality improvement. She proposed a new paradigm of sexual and reproductive health that targets both men and women in an effort to revise existing interpretations of sexuality, relationships, and male perspectives on the value of health. Challenges included the predominance of Catholicism and the moralistic view towards sexuality, machismo, and discriminatory attitudes towards women. Plata acknowledged the need to simultaneously expand the health care services provided in order to attract

men and to ensure the sustainability of programs by opening unisex clinics in smaller towns.

In Brazil, the model of masculinity traps men between the cultural expectations of virility and transgression. The concept of transgression has both public and private manifestations: men are expected to act out of cultural norms both in public (*sacanagem*) and in private (within their own four walls) to prove their masculinity.

### **Panel 5: Violence**

#### **Oswaldo Montoya, Puntos de Encuentro, Nicaragua. “The Conclusions of the Working Group on Masculinity and Violence.”**

Montoya reported on a set of recommendations to address the issue of men and violence. The recommendations were developed by a group of 10 members from different countries in Latin America during a conference sponsored by FLACSO in Santiago de Chile. The first task of the group was to agree on some fundamental premises related to masculinity and violence. The group offered recommendations in four categories: consciousness-raising and prevention, public legislation and policies, intervention programs, and research proposals. The task ahead is to implement these recommendations throughout Latin America.

#### **José Aguilar Gil, Mexfam, Mexico. “The Qualitative Evaluation of *La hora del amigo*.”**

Aguilar introduced the video *La hora del amigo*, which was produced with the support of IPPF. Aguilar spoke of the difficulties of producing a video that does not stigmatize men, yet addresses the difficult issues related to men and masculinity. The video consists of many vignettes of experiences of Mexican men. The issues addressed in the video are varied and include domestic violence, sexual harassment, alcohol abuse, relationship issues, fatherhood, and sexuality. Mexfam measured the usefulness of the video through two means. First, group discussions about the video were conducted to qualitatively measure viewers’ reactions and perceptions of the video. Second, an educational session using the video was evaluated. The findings from these groups indicated different perceptions between some men and women. Different perceptions based on different age groups also surfaced. For example, most young men acknowledged that the myriad of issues presented in the video were real problems that people deal with on a regular basis, while many older men insisted that these issues did not occur in their neighborhoods.

### **Panel 6: A New Paradigm of Masculinity**

#### **Juan Carlos Hernández, XochiQuetzal, Mexico. “Familial Construction.”**

Hernández provided an overview of the work XochiQuetzal does to build democratic families based on gender equality in which members have a right to be themselves and enjoy “responsible pleasure”—that is, enjoy themselves as long as it is not harmful to others or themselves. Hernández placed this work in the “*cultura mortificante*,” a culture that relies on fear, ignorance, and shame and counts on men, as fathers, to enforce the orders. Hernández concluded that, as a consequence of being the police-

men of the *culutra mortificante*, men cannot enjoy paternity. He then illustrated some of the exercises men and women do in “schools for mothers and fathers” where they are presented with alternative options, such as making democratic decisions, based on rules established by the family and consensus reached within the family.

### **Panel 7: Strategies for Including Men in Reproductive Health Programs**

#### **Fredy Hernán Gómez Alcaraz, Universidad Nacional de Colombia, Colombia. “Service Providers in Sexual and Reproductive Health and Decision-Making by Couples, Profamilia, Colombia.”**

Using the Colombian social and political context as a backdrop, Gómez Alcaraz looked at how service providers have started to consider interpersonal communication, as well as cultural and institutional factors, in developing the content of their program strategies. Using the experience of Profamilia in providing vasectomy services and placing special emphasis on male participation, he suggested that service providers create a space for legitimization of ethical precepts and moral models that are transmitted by providers to clients. This transmission influences the social significance placed upon these same decision and communication processes between couples. Interpersonal relationships occur within the process of providing services. Intervention by service providers into the personal realm of individuals is guided and legitimized by technical and scientific knowledge in terms of the medical establishment’s understanding of sexuality and reproduction. This process necessarily introduces concepts and values regarding the human body, the construction of generic identities, and relationships between men and women, and it has the effect of transforming the population into potential users of family planning methods and services. Gómez Alcaraz also made the suggestion that service providers are in constant interaction with their social, political, and economic context given that the products, programs, and services they provide are subject to the legal constitutional framework of the health, justice, and education sectors.

#### **Francisco Cervantes Islas, CORIAC, Mexico. “Paternity as a Process of Reflection and Change within Men.”**

In his presentation, Cervantes Islas looked at the construction of paternal identity in men within the context of social dilemmas and factors. He considered the premises and strategies that have been promoted by CORIAC to foster a more pleasant and participatory fathering experience for men. In addition, he included some personal reflections on his experiences as a father to suggest various analytical links with which to approach the construction of paternal identity. Cervantes Islas challenges the audience to change the way it looks at paternities within the context of changing sexual roles and macro- and micro-social transformations whereby the role of women, masculinity, economic capacity, assimilated values, education, and individual characteristics all combine to form different childrearing practices. He suggested the following methodologies to increase men’s active participation in childrearing: (1) interventions that progressively and regularly question traditional, authoritarian paternal roles and practices; (2) the promotion of paternity, not as an obligation, but as a right of men, to strengthen its social image as well as emphasize the needs and commitments that men

have as fathers; and (3) for educators/facilitators, he recommends “re-signifying” the concept of education from guide to support for growth, in and of itself. The objective of these recommendations would be the creation of more affective, democratic, and open value systems based on reflexive processes that lead to the rational practice of respect within the family unit, such that *paternaje* would be expressed through empathy and nonviolence.

**Milton Cordero, Profamilia, Dominican Republic. “Incorporating Men into Reproductive Health: *Hombre ponte en eso.*”**

Milton Cordero presented the experience of Profamilia-Dominican Republic in reaching out to Dominican men to increase men’s protection against STDs/HIV as well as to increase the use of family planning methods by men. In order to achieve these goals, Profamilia designed a multimedia (radio, television, print) campaign to foster a social environment conducive to men’s constructive involvement in reproductive health. It pursued a variety of activities in its strategy: interagency collaboration, service and IEC committees, training of service providers, and monitoring and evaluation studies. The media campaign was modestly successful in reaching the intended audience (76.7% of men surveyed had seen a TV spot/51.4% of men surveyed had heard a radio announcement). Even with wide exposure, men still struggled with relating family planning with STD protection. Dr. Cordero cited important lessons learned from the project to help guide future media campaigns. The slogan itself “*Hombre Ponte en Eso,*” was not clearly linked enough with the concept of men participating in family planning/reproductive health. Also, future campaigns would benefit from community support through the training and usage of educational materials.

**Katia Ratto, Maternidade Leila Diniz, Brazil. “Male Participation during Pregnancy and Birth.”**

Based on field study research conducted at the Maternidade Leila Diniz (MLD) birthing center, the first public institution in Brazil to offer “accompanied birth” to expectant mothers, Ratto presented the experiences of the MLD with male participation during pregnancy and birth. She began her presentation with a discussion of the cultural definition within Western civilization of labor and birth as medical, not natural, events, which has made them alien to the actual life experience of common people. This results in the creation of a detrimental birthing environment lacking in human warmth and emotional support for the expectant mother, as evidenced by hospital practices (e.g., C-sections and the use of forceps) and attitudes of service providers that prevent a mother’s early interaction with her newborn. If this situation excludes mothers, then it is certainly the case that fathers are excluded even more. Ratto argues against Western theories of early childhood development that place primacy on the role of the mother, and notes the “psychological re-adaptation necessary by both fathers and mothers as they integrate the roles of children and conjugal partners with that of future parents” (Yogman, 1980). Indeed, psychological studies indicate that fathers’ interaction within the triad demonstrates that they play a more active role than the stereotype of “fathers as passive participants” suggests. Ratto found that during the first year of the MLD’s “accompanied birth” initiative, hospital staff demonstrated some resistance to the idea but that acceptance, approval and demystification of the concept of “accompaniment” was achieved over time. The MLD model is being rep-

licated in other institutions in Rio de Janeiro. It is hoped that this birthing center model, which seeks a greater physical and emotional incorporation of fathers, can be expanded to other institutions throughout Brazil.

**Appendix B**  
**Agenda**  
**Male Participation in**  
**Sexual and Reproductive Health: New Paradigms**

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**Day 1**  
**Saturday, October 10**

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9:00–5:00pm

*Arrival and Registration*

6:00–8:00pm

*Inauguration*

Master of Ceremonies: Humberto Arango, IPPF/WHR

Dr. Gregorio Pérez Palacios, General Director of Reproductive Health,  
Ministry of Health, Mexico

Dr. Amy E. Pollack, President, AVSC International

Dr. Hernán Sanhueza, Regional Director, IPPF/WHR

Dr. Rainer Rosenbaum, Representative, UNFPA, Mexico

8:00–10:00 p.m.

*Welcome Cocktails and Buffet*

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**Day 2**  
**Sunday, October 11**

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7:00 a.m.

*Buffet Breakfast*

El Tule Restaurant

8:45–9:00 a.m.

*Announcements*

*Introduction to the Symposium*

Judith F. Helzner, IPPF/WHR

9:00–10:45 a.m.

***Panel 1: Masculinities-History, Theory, and Definitions***

Moderator: Javier Alatorre, INSP, Mexico

José Olavarría, FLACSO, Chile

Richard Parker, Columbia University, USA

Commentator: Juan G. Figueroa, Colegio de México, Mexico

11:15–12:30 p.m.

*Discussion*

12:30–2:30 p.m.

*Lunch*

El Tule Restaurant

**Day 2 – continued**

2:30–4:30 p.m.

***Panel 2: Masculine Sexuality: Youth***

Moderator: Luz Helena Monsalve Ríos, Ministry of Health, Colombia

Rosana Gregori, ECOS, Brazil

Gary Barker, Chapin Hall Center for Children, USA

***Discussion***

4:30–5:00 p.m.

**Break**

5:00–6:30 p.m.

***Panel 3: STDs/HIV/AIDS***

Moderator: Consuelo Juárez, AVSC International, Mexico

Ney Costa, BEMFAM, Brazil

Roberto Granulles, FEIM, Argentina

***Discussion***

7:00–9:00 p.m.

***Guelaguetza Dinner***

Hotel Victoria Garden

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**Day 3  
Monday, October 12**

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7:00 a.m.

***Buffet Breakfast***

El Tule Restaurant

8:30–8:45 a.m.

***Announcements***

8:45–10:45 a.m.

***Panel 4: Masculine Sexuality: Programmatic Strategies***

Moderator: Alcides Estrada, AVSC International, Colombia

Debbie Rogow, USA

Benno de Keijzer, Salud y Género, Mexico and

Oscar Contreras, ReproSalud, Peru

Maria Isabel Plata, Profamilia, Colombia

***Discussion***

10:45–11:00 a.m.

***Break/Group Picture***

**Day 3 - continued**

11:00–1:00 p.m.

***Small Working Groups***

- ❖ Designing a Program for Men
- ❖ Parameters of Adolescents' Programs
- ❖ Men and Contraception
- ❖ Men and STD/HIV Prevention
- ❖ Mass Media, Part I
- ❖ Clinics for Men

1:00–2:30 p.m.

***Lunch***

El Tule Restaurant

2:30–4:45 p.m.

***Panel 5: Violence***

Moderator: Margareth Arilha, ECOS, Brazil

Oswaldo Montoya, Puntos De Encuentro, Nicaragua

Presentation of the results from the evaluation of the video *La hora del amigo*. José Aguilar Gil, Mexfam, Mexico

***Discussion***

***Free Night***

Free time in Oaxaca

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**Day 4**

**Tuesday, October 13**

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7:00 a.m.

***Breakfast Buffet***

El Tule Restaurant

8:30–8:45 a.m.

***Announcements***

8:45–10:00 a.m.

***Panel 6: The New Paradigm of Fatherhood***

Moderator: Ivan Prudencio, IPPF/WHR, Bolivia

Juan Carlos Hernández, Xochiquetzal A.C., Mexico

***Discussion***

10:00–11:15 a.m.

***Panel 7: Strategies to Involve Men in Reproductive Health Programs***

Moderator: Gonzalo Perez Benavides, Psychologist, Chile

Francisco E. Cervantes Islas, CORIAC, Mexico

Fredy Gómez, National University of Colombia, Colombia

***Discussion***

11:15–11:30 a.m.

***Break***

**Day 4 - continued**

11:30–1:00 p.m.

*...Continuation*

Katia Ratto, Maternidade Leila Diniz, Brazil

Milton Cordero, Gynecologist, Dominican Republic

*Discussion*

1:00–2:30 p.m.

*Lunch*

El Tule Restaurant

2:30–4:30 p.m.

*Small Working Groups*

- ❖ Masculinity and Fatherhood
- ❖ Male Involvement in Pregnancy and Childbirth
- ❖ Reproductive Health Services/Gender Equity in Reproductive Health Services
- ❖ Violence
- ❖ Mass Media/IEC Campaigns, Part II

4:30–5:00 p.m.

*Break*

5:00–6:30 p.m.

*Poster Session*

Visual exhibition of projects and programs with institutional representatives present to answer questions

6:30–8:00 p.m.

*Video Viewing*

Organizations will have the opportunity to show their videos

*Free Night*

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**Day 5**

**Wednesday, October 14**

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7:00 a.m.

*Buffet Breakfast*

El Tule Restaurant

8:30–8:45 a.m.

*Announcements*

8:45–11:15 a.m.

*Country Action Plans*

Groups made up of representatives from each country or region

*Objectives:*

- (1) To give the participants the opportunity to learn what other institutions in their country are working on
- (2) To foster communication and collaboration between institutions to maximize regional resources

**Day 5 - continued**

11:15–11:30 a.m.

***Break***

11:30–1:00 p.m.

***Panel 8: The Challenge of Funding***

Moderator: Cynthia Steele, AVSC International, New York

Lucille Atkin, Ford Foundation, Mexico

Belkys Mones, UNFPA, Chile

Ana Luisa Liguori, MacArthur Foundation, Mexico

Carlos González, Schering, Colombia

1:00–3:00 p.m.

***Lunch and Closing Ceremonies***

Master of Ceremonies: Alfonso Lopez Juárez, Mexfam, Mexico

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