

When the Client Is Male: Client-Provider Interaction from a Gender Perspective

By Karin Ringheim

Karin Ringheim is a senior program officer of the Program for Appropriate Technology in Health, Washington, DC.

Client-provider interaction is the verbal and nonverbal communication that occurs between staff of a health care program and individuals seeking information or services. Good client-provider interaction is one goal of a worldwide movement that places family planning and reproductive health in a human rights context,¹ in which responding to the client's needs rather than achieving a demographic or other outcome is the primary objective.

Essential elements of good client-provider interaction are respectful treatment (including respect for the client's right to confidentiality and privacy), respect for a woman's right to make decisions about her body, voluntary and informed choice, and incorporation of a gender perspective.² Current guidelines for client-provider interaction generally assume that the client is a woman. There is little empirical evidence to suggest how or why client-provider interaction should be modified when the client is a man or a male-female couple. This article examines the available literature and empirical data to highlight benefits and potential pitfalls in client-provider interaction when the client is male, and it includes suggestions for provider training to maximize benefits and reduce risks.

RATIONALE FOR MALE INVOLVEMENT

The International Conference on Population and Development (ICPD) in 1994 called on organizations that historically had provided family planning and other reproductive health services to women to constructively involve men in their programs for the benefit of both men and women. Women's health advocates and feminists initially asked whether involving men risked diverting resources from women and encroached on their reproductive freedom. These concerns, however, have lessened with the growing recognition, spurred on by the HIV epidemic, that the reproductive health of individuals largely depends on a relational act occurring between two people. Considering these relationships as central to reproductive health programs and services is now generally recognized as useful and necessary. The Joint United Nations Programme on HIV/AIDS (UNAIDS) World AIDS Campaign focused in 2000 and 2001 on involving men, particularly young men. The agency says that more than 70% of HIV infections occur as a result of heterosexual intercourse and an additional 5–10% through sex between men.³ According to the director of UNAIDS, Peter Piot, "Men are key to reducing HIV transmission and have the power to change the course of the AIDS epidemic."⁴

In fact, as the Population Council found with non-

governmental organizations (NGOs) that provide reproductive health services in India, many providers have added men to their services not because it was recommended by ICPD or UNAIDS, but as part of an "evolutionary process," recognizing that "there could be only limited improvement in women's reproductive health without men's support and active involvement."⁵ Moreover, women have increasingly made it known to service providers that they are powerless to implement changes suggested by the provider to protect their own health:

"Why don't you give this advice about what I should eat [during pregnancy] to my family members? If I start eating what you suggest, my husband and mother-in-law will beat me."—*Woman in Ahmedabad, India*⁶

In Pakistan, women responded to advice given during a seminar on safe motherhood by pointing out that although they were now better informed, they were without the power and the financial resources to act on the new knowledge. Men control the decision to seek health care as well as the money to pay for it.⁷ Such pleas from women have led, in many countries, to "reality-based" male-involvement programs that recognize men's authority within the family, while trying to influence its use for the benefit of both women and men.

INTRODUCING A GENDER PERSPECTIVE

"Involving men" often means including them in counseling sessions, either alone or with their female partners. What does it mean to bring a gender perspective to client-provider interactions that involve men? There are several elements.

According to Raju and Leonard, "The process of 'bringing men in' needs to be carefully considered so that in no way are we undermining the often precarious rights of women to control their own bodies and make their own decisions. If men participate because of a demand from women, then we will see a shift in the social construct that is being spearheaded by women themselves. Yet, it must always be kept in mind that what needs to be protected at all costs is the right of each individual woman not to involve her partner if she so chooses—without the need of an explanation."⁸

At the same time, the historic focus on services for women has led to neglect of men's need for reproductive health information and services, often to the disadvantage of both men and women. Men are often less knowledgeable about anatomy and physiology than are women, but more reluctant than women to show their ignorance. A survey in India⁹ and an intervention study in Pakistan¹⁰ each documented

that even educated men lacked knowledge about reproductive health issues. Men have a right to and need for reproductive health information and services.

The provider must therefore consider the existing gender and social inequalities between men and women that affect reproductive health, as well as how to meet men's needs for information and services in a way that does not diminish attention to women. It is a complex process. High-quality client-provider interaction with male clients endeavors to ensure that programs promote gender equity to benefit both men and women. It meets men's needs while focusing primarily on a woman-centered agenda. Although couple counseling may stimulate positive communication within the relationship, there are circumstances in which both men and women are better served by individual interactions with a provider.

Client-provider interactions in all spheres of reproductive health can benefit from attention to gender issues. This article addresses client-provider interactions with men in the areas of family planning, violence prevention, postabortion care and safe motherhood.

Family Planning

Among these four reproductive health areas, family planning is the one in which the field has the most experience in involving male clients. Including men in programs and services has become increasingly common in the past decade, and there is a large body of literature on male involvement and communication between partners. Yet, there is little empirical information on how the dynamics of interaction change when a male client is present.

There is evidence of provider bias against male clients¹¹ and of providers making men feel uncomfortable and unwelcome,¹² failing to give them accurate information about male contraceptive methods such as vasectomy¹³ and violating their rights to privacy and confidentiality.¹⁴

There is also evidence, however, that when men are counseled along with women, men get more than their share of the attention. In Kenya, an analysis of family planning counseling sessions with women, men and couples revealed that men were much more likely than women to ask questions and volunteer information. Sessions with men and couples lasted more than twice as long as sessions with women. On the positive side, providers encouraged more communication within couples, as well as male responsibility for family planning, when both partners were present.¹⁵ However, providers also disagreed with or ignored women's input 28% of the time, while always responding supportively to men's comments and questions.¹⁶ This preferential treatment may have been attributable, in part, to the novelty of serving male clients; still, the researchers concluded that Kenyan providers gave better care to men than to women. Such unintended consequences of involving male partners highlight the need for providers to be aware of gender dynamics, both between the couple and between the client and provider. The researchers recommend that providers be trained to encourage women to speak and to ensure that

women's concerns are heard and addressed.¹⁷

Vasectomy is a viable but underutilized contraceptive option for those who have reached their desired family size. There are only three countries in the world*—none of them in the developing world—where the number of vasectomies equals or exceeds the number of female sterilizations,¹⁸ despite the fact that vasectomy is easier, safer and less expensive to perform. Efforts to train male promoters of family planning and observations of client-provider interactions in Bangladesh and India illustrate that both male and female providers share client biases against vasectomy: Providers are likely to convey to clients that vasectomy causes impotence and weakness and that, contrary to fact, it is less safe and more expensive than female sterilization.¹⁹ Thus, providers and male clients alike may share the belief that it is unnecessary to impose vasectomy on men, when women can undergo sterilization instead. Such beliefs, based on gender biases that place less value on women's health, are not alterable merely by conventional training on the benefits of vasectomy. Training must also confront the gender biases that underlie these strongly held assumptions of male privilege.

In countries where there is a cultural reluctance for men and women to discuss sexual and reproductive health issues, overcoming this barrier early in marriage can lead to sustained improvements in spousal communication. The Society for Education, Welfare and Action (SEWA)-Rural, an NGO in Gujarat, India, includes men in reproductive health in several ways: For example, the society works with newly married couples—alone and with their elders—to initiate and improve communication about reproductive health issues. Although most young couples are eager to learn more about reproductive health, SEWA-Rural found that the health workers themselves were inhibited about discussing such matters and had more trouble getting over their own preconceived notions about sexual behavior than did the newlyweds. Specialized training was required before health workers could address sexuality and gender equity. SEWA-Rural found that it was best to conduct multiple sessions over a period of weeks and to cover only a few topics per session. This format avoided information overload and allowed the staff to process and internalize the training, especially because it challenged their own values and comfort level. Now, teams of male and female health workers promote improved communication skills and gender awareness between partners and among family members. The approach is holistic, viewing the family as the potential beneficiary of a comprehensive package of health services.²⁰

The Society for the Integrated Development of the Himalayas (SIDH), an NGO in Uttar Pradesh, India, wanted to raise young men's awareness of and support for women's reproductive health by making known the link between gender and human rights issues. In a project supported by the Program for Appropriate Technology in Health (PATH), SIDH found that young men became defensive when

*The United Kingdom, New Zealand and the Netherlands.

In some circumstances, involving male partners in client-provider interactions can place women at considerable risk of violence.

women's health issues were raised. The young men were resistant to the concept of gender equity because they feared losing the power to which they felt entitled. After having an opportunity to articulate their own concerns, however, the young men were able to listen more sympathetically to women's concerns. Both men and women were found to believe that maleness is associated with the quality and quantity of semen and that loss of semen can be debilitating. Thus, both women and men were reluctant to "waste" semen by using condoms. Men's preoccupation with semen loss was a serious issue that caused considerable psychological distress. Giving attention to this issue made men more open to considering the impact of gender disparities on women's health, including the risks of not using condoms. The interactions between providers (in this case, SIDH trainers) and clients also modeled respectful treatment of women and highlighted the benefits of harmonious relationships between the sexes in achieving greater intimacy and happiness in the home.²¹

Violence Prevention

The ReproSalud Project, a program funded by the U.S. Agency for International Development (USAID) to improve the reproductive health of poor women in Peru, did not begin as a violence prevention intervention or one involving male partners. As women were made aware of their human right not to be forced to have sex or be abused, they demanded that their husbands be included in the program. An NGO from Mexico, Salud y Genero, was brought in to train health workers to help men reflect on the "experiences of abuse and mistreatment that they themselves may have suffered or witnessed"²² and relate them to the abuse that they inflicted on others. Sensitizing men in this way proved to be powerful in promoting change in gender dynamics. Men reported profound personal changes in behavior that were corroborated by their female partners:

"The husbands who have been trained understand better. Before, they brutally forced sex. They hit, especially when they were drunk. Now, no more."—*Female project staff, age 32*²³
An assessment of the project documented dramatic decreases in alcohol consumption, domestic violence and forced sex in the project areas.²⁴

In some circumstances, involving male partners in client-provider interactions can place women at considerable risk of violence. In western Kenya and elsewhere in traditional pockets of Sub-Saharan Africa, cultural pressures to bear children are such that men may oppose women's use of contraceptives.²⁵ Women who want to space births assume that their husbands will not be supportive and often feel compelled to use a method without their partners' knowledge. An estimated 6–20% of women practicing contraception in Sub-Saharan Africa use contraceptives without their husbands' knowledge.²⁶

A woman who is found to be using a method covertly may be subject to violence. Where violence is seen as a means of monitoring and correcting women's behavior, women may be as likely as men to believe that it is appropriate to beat a

woman for certain "transgressions," including covert contraceptive use. Some 51% of women and 43% of men in a study in Ghana agreed that a husband is entitled to beat his wife if she uses contraceptives without his knowledge.²⁷ Other men claim that it is not the use of contraceptives, but the decision to bypass male control that leads to violence:

"We are not against the use of these methods, but if a woman comes to the clinic without her husband, [you should] insist that she bring her husband. These women are trying to take control of our homes as decision-makers."—*Young man from Naga, Ghana*²⁸

In such an environment, efforts to involve male clients must be undertaken with great caution. Influencing social norms and promoting an understanding of the benefits of family planning at the community level may be a necessary first step, because women are potentially endangered both by covert use and by the involvement of the partner in joint counseling.

No other area is as potentially risky when involving men than counseling and testing for sexually transmitted infections (STIs), especially HIV. In many instances, women are justifiably fearful of partner violence or abandonment if they are found to have an STI or to be HIV-positive. A study conducted by the Population Council in Tanzania found that one in four female clients at an HIV/AIDS voluntary counseling and testing site said that violence was "a major problem" in their lives. In that study, violence was identified as both a risk factor for acquiring HIV and a feared response to a positive diagnosis. After adjustment for age and other demographic factors, HIV-positive women aged 18–29 were 10 times as likely as HIV-negative women to have experienced a violent episode by a current partner. In addition, fear of the partner's violent reaction was the main reason that women did not disclose their HIV status to the partner.²⁹

At this voluntary counseling and testing site, couple counseling is available for those who come to be tested together. The partners receive pretest counseling jointly. In the posttest session, however, partners receive their own results separately and are counseled individually. The partners are then given the opportunity to jointly discuss the results with a counselor if they both wish to do so. Most couples accept this offer. The researchers conclude that providers should screen for partner violence and help women develop safe disclosure plans for communicating with their partners. They also recommend that because of high levels of partner violence, community-based efforts to address sexuality and violence are needed to change social norms and promote nonviolent resolution of conflicts.³⁰

Postabortion Care

The experience of an abortion, whether spontaneous or induced, is often accompanied by much anxiety and uncertainty. Although husbands frequently accompany their wives to the hospital, there have been few efforts to involve men in postabortion care, which includes counseling about postabortion family planning. A study conducted by the

Population Council in Kenya, in five hospitals in which more than one in three admissions to the gynecological ward were for complications of induced abortion, found that only 14% of men interviewed had received any information on their wife's condition, whereas 94% said they would have liked to receive such information. Similarly, just 15% of men received information about family planning after the procedure, although 92% said they would have liked to.³¹

In Egypt, the Population Council conducted operations research to determine if male involvement improved the recovery of postabortion patients. Husbands of women who were admitted to the hospital for complications of abortion were counseled about the role they could play in their wife's recovery and about use of family planning. On the basis of previous work showing that women felt less willing to ask questions or express concerns when their husbands were present,³² men were counseled separately. The messages that were given included the wife's need for rest and adequate nutrition, warning signs indicating a need for follow-up, the return of fertility within two weeks and the need for family planning to avoid another pregnancy. Early in the study, however, it was found that when providers were trained to counsel husbands, they sometimes neglected to give the same information to wives; thus, husbands' counseling replaced, rather than reinforced, attention to wives. The results also indicated that men were more receptive to counseling by senior and better-trained medical staff. These providers had a stronger impact on the husbands' behavior in providing their wives with emotional support after the abortion. The researchers noted that counseling of husbands must always be given in addition to, rather than in place of, patient counseling.³³

It is sometimes necessary for counselors to exercise more than customary tact and diplomacy when counseling men. In Turkey, withdrawal is the most widely used contraceptive method, and failure of withdrawal is cited as the reason for more than half of all unintended pregnancies that end in abortion. Although abortion is legal, it requires the consent of the husband. This requirement, despite its patriarchal origins, has facilitated efforts to include husbands in postabortion family planning discussions. In a large Ankara hospital, EngenderHealth (formerly Access to Voluntary and Safe Contraception International, AVSC) worked with physicians and counselors to provide counseling to couples about both the abortion procedure and family planning options, including vasectomy. Counselors were sometimes called on to conduct marital counseling when women became angry with their husbands because the contraceptive method had proven ineffective, whereas their husbands expressed skepticism that withdrawal had actually failed. According to a staff psychologist, it was not uncommon for the husband to claim that the child was not his, "but after we explain the physiology and anatomy, the couple usually understands."³⁴ Joint counseling of couples proved to be highly effective—98% of couples adopted a modern method of contraception after the abortion, and the number of subsequent abortions fell by almost half.³⁵

Safe Motherhood

Safe motherhood is an area in which male involvement would seem least controversial, although few efforts have so far been made to determine whether including men in safe motherhood programs has an effect on reducing maternal mortality and morbidity. Men often control decisions of family members to seek health care but do not understand when medical attention is needed. They also may be reluctant to show their ignorance of reproductive health and physiology. A study of men's reproductive health knowledge in Uttar Pradesh, where the maternal mortality ratio is more than 700 deaths per 100,000 live births, found that men had little awareness of serious complications of pregnancy and childbirth. About half of the 6,700 husbands interviewed could not name one danger sign.³⁶

The Frontiers Project, implemented by the Population Council, is supporting two efforts to determine whether men's participation in antenatal care has a positive impact on maternal health and birth outcomes. Formative research in South Africa showed that both men and women wanted men to become involved in pregnancy care. Women felt that providers would be better able to get messages across to their partners about issues they themselves were not able to discuss. By promoting "Pregnancy as a Family Responsibility," the project has developed training for providers in couple counseling, as well as in how to provide higher-quality care to women.³⁷ Providers are also trained to help clients assess their risk of STIs. In a companion study in India, higher provider morale resulting from increased client satisfaction has helped offset the added time needed for counseling clients.³⁸ These studies will be important additions to the literature on constructive involvement of men.

In Delhi, workshops conducted by the Community Aid and Sponsorship Program and Foster Parents Plan International to increase men's awareness of antenatal care and safe motherhood issues have led to increased attendance at antenatal care clinics by women in the first trimester of pregnancy. The timing and season of the year were important factors in scheduling workshops: Men wanted to participate only on Sundays, preferably during the winter and not during their favorite television programs!³⁹

IMPLICATIONS FOR PROVIDER TRAINING

To be willing to change, men must be able to identify the advantages of a less hierarchical relationship with women. If the interactions between providers and clients can help men understand the benefits of a less confining sense of masculinity—for example, greater happiness and intimacy in marriage—men may be more likely to accept suggestions that they help their spouses, treat women with respect and stop using violence to "correct" women's behavior. Conventional provider training, however, does not help providers examine gender power dynamics or reflect on the differing interests of men and women. It has been argued that gender training must occur simultaneously with general efforts to empower women and sensitize men.⁴⁰ As a result, providers and the community will together ulti-

To be willing to change, men must be able to identify the advantages of a less hierarchical relationship with women.

mately affect both the “supply” of providers with skills for good client-provider interaction and the “demand” by clients for equitable and respectful treatment.

Because provider and client attitudes are generally the product of the same cultural context, providers may sometimes unconsciously defer to male clients. Training that challenges a provider’s deeply engrained beliefs and practices is thus essential in making client-provider interactions with men successful. Furthermore, when counseling couples, providers need to be skillful in attending to both partners. One technique is to solicit the woman’s opinion in a supportive and respectful manner. Another is to recognize when couples are best counseled separately—for example, when discussing sexual behavior that may occur outside the relationship.

To offer contraceptive and reproductive health services of good quality, providers must also skillfully address sensitive issues in a manner that maximizes the clients’ comfort level. Providers, however, may first need to increase their own comfort level when discussing sexuality and using sexual language. Exercises that assist them in clarifying their values—for example, how they feel about sexual practices that the client may engage in—may avert judgmental and counterproductive interactions with the client.

Some successful training approaches that have been developed to facilitate working with male clients include activities that aim to raise the comfort level of providers. An NGO in Gujarat, India, Social Action for Rural and Tribal Inhabitants of India (SARTHI), found that its attempts to work with men were hampered by a lack of openness and sensitivity to sexual issues among its mostly volunteer health workers. The group’s approach to training was to rely more on experiential and participant-centered exercises than on clinical or topical methodologies. Techniques such as “body mapping,” in which participants mark the parts of a drawing of the body that give pain or pleasure confirmed that staff were reluctant to address sexuality. A question box was then introduced to allow staff to ask candid questions anonymously. In combination with ongoing support and upgrading of skills, these techniques have enabled health workers to address gender and sexual issues with both male and female household members.⁴¹

Profamilia’s Clinica Para El Hombre has operated in Bogota, Colombia, since 1995. Its objectives regarding staff training include helping providers feel more comfortable with their own sexuality, reflect on their personal attitudes about male and female roles, and apply their thinking about sexuality and gender roles to their interaction with clients. Male clients were found to be less knowledgeable about reproductive health and less accustomed to physical exams than were female clients. Moreover, according to a sex therapist at the Bogota clinic, women easily accepted blame for problems, but had difficulty talking about their sexual experiences. In contrast, men could talk easily about their sexual experiences but were less likely than women to blame themselves for any problems.⁴² Providers also found that male clients were more demanding of attention from staff and less patient about waiting for services:

“Some men come and want to be seen immediately. Some yell or get impatient. This is something that you rarely see with women.”—*Female counselor*⁴³

Exploring the social construction of masculinity and how it allows men, but not women, to more easily demand rights—for example, to privacy—has been illuminating for the staff. According to Profamilia Director Maria Isabel Plata: “Our male experiences taught us how important the privacy issue is. If we asked men in public when they last had a sexual experience, they would refuse to answer. Women would often answer in a low voice. The men’s clinic taught us the importance of privacy because the men complained from the beginning. This started changing how we looked at the issue of privacy [for women as well].”⁴⁴

Other counselors have noted that men are more likely to bring up personal problems because they feel they have no one else to talk to about them. The staff at Profamilia’s clinics for men exemplify good client-provider interaction as applied to men:

“We don’t see the patient as a prostate gland but as a man with a need. I look for the person behind that need. For the client, this means that the doctor provided a good service but also recognized the patient as a person. This is important, because sometimes a man comes for medical attention but really what he wants is more counseling and attention.”—*Clinic staff*⁴⁵

Working with men helped the staff recognize that women also have a need for counseling and are no less entitled to good service simply because they are less vocal than men in demanding it.

CONCLUSION

Providers who deal with male and female clients must be sensitive to gender roles and how they factor into client-provider interaction. Acknowledging their own tendencies to give greater status and attention to male clients is important if providers want to avoid shortchanging the female client in an interaction involving a couple. For the male client, the modeling of respectful treatment of the female partner by the provider has the potential to influence the couple’s relationship.⁴⁶ Attention to gender equity in client-provider interactions is essential to ensuring that involving males adds value instead of posing an obstacle to improving women’s and men’s reproductive health.

REFERENCES

1. Alcala M, Preface to *Commitments to Sexual and Reproductive Rights for All*, New York: Family Care International, 1995.
2. Murphy E and Steele C, Client-provider interactions (CPI) in family planning services: guidance from research and program experience, in: *Maximizing Access and Quality*, Working Paper, Washington, DC: U.S. Agency for International Development, 2000, Vol. 1, No. 2; and International Planned Parenthood Federation Western Hemisphere Region (IPPF/WHR), *How Gender-Sensitive Are Your HIV and Family Planning Services?* New York: IPPF/WHR, 2002, <http://www.ipppfwhr.org/resources/gender_continuum.html>, accessed July 17, 2002.
3. Piot P, Joint United Nations Programme on HIV/AIDS (UNAIDS), *World AIDS Campaign: Men Key to Reducing HIV/AIDS. New Campaign Targets Widely Held Beliefs About Masculinity*, news release, Melbourne,

- Australia: UNAIDS, Oct. 7, 2001, <http://www.unaids.org/whatsnew/press/eng/pressarc01/WAC_071001.html>, accessed July 17, 2002.
4. Ibid.
 5. Raju S and Leonard A, Nongovernmental organizations pave the way, in: Raju S and Leonard A, eds., *Men as Supportive Partners in Reproductive Health, Moving from Rhetoric to Reality*, New York: Population Council, 2000, p. 3.
 6. Centre for Health, Education, Training and Nutrition Awareness (CHETNA), Narrowing the gender gap by enhancing men's involvement in reproductive health, in: Raju S and Leonard A, 2000, *ibid.*, p. 30.
 7. Kamal I, Field experiences in involving men to promote safe motherhood. The Pakistan experience, paper presented at the World Health Organization (WHO) Meeting of Regional Health Advisors on Programming for Male Involvement in Reproductive Health, Washington, DC, Sept. 5-7, 2001.
 8. Raju S and Leonard A, 2000, *op. cit.* (see reference 5), p. 51.
 9. Bloom S et al., What husbands know in Northern India about reproductive health: correlates of knowledge about pregnancy and maternal and sexual health, *Journal of Biosocial Science*, 2000, 32(1): 237-251.
 10. Kamal I, 2001, *op. cit.* (see reference 7).
 11. Ringheim K, Reversing the downward trend in men's share of contraceptive use, *Reproductive Health Matters*, 1999, 7(14):83-96.
 12. Pile J et al., Involving men as partners in reproductive health: lessons learned from Turkey, AVSC Working Paper, New York: AVSC, 1999, No. 12, p. 5.
 13. Piet N et al., *Men in India, Bangladesh and Pakistan: Reproductive Health Issues*, Delhi, India: Population Council, 1999, pp. 90-91.
 14. AVSC and Profamilia, *Profamilia's Clinics for Men: A Case Study*, New York: AVSC and Bogota, Colombia: Asociación Profamilia, 1997.
 15. Kim YM, Counseling and communicating with men to promote family planning in Kenya and Zimbabwe, paper presented at the WHO Meeting of Regional Health Advisors on Programming for Male Involvement in Reproductive Health, Washington, DC, Sept. 5-7, 2001.
 16. Kim YM et al., Difference in counseling men and women: family planning in Kenya, *Journal of Patient Education and Counseling*, 2000, 39(1):37-47.
 17. Ibid.
 18. United Nations (UN), *World Contraceptive Use Data Sheet*, 1998, New York: UN, Department of Economic and Social Affairs, Population Division, 1999.
 19. Piet N et al., 1999, *op. cit.* (see reference 13).
 20. Society for Education, Welfare, and Action-Rural, Enhancing roles and responsibilities of men in women's health, in: Raju S and Leonard A, 2000, *op. cit.* (see reference 5), p. 29.
 21. Gupta P, Joshi A and Crook B, Gender and social justice: nurturing young men's partnership with women to improve reproductive health. A case study of the central Himalayas, Washington, DC: Men and Reproductive Health Subcommittee of the U.S. Agency for International Development Interagency Gender Working Group, 2002 (forthcoming).
 22. Rogow D, Alone you are nobody, together we float: the Manuela Ramos movement, *Quality/Calidad/Qualité*, New York: Population Council, 2000, No. 10, p. 15.
 23. Ibid., p. 20.
 24. Ibid.
 25. Rutenberg N and Watkins SC, Conversation and contraception in Nyanza province, Kenya, paper presented at the annual meeting of the Population Association of America, New Orleans, LA, USA, May 9-11, 1996.
 26. Biddlecom A and Fapahunda B, Covert contraceptive use, prevalence, motivations and consequences, *Studies in Family Planning*, 1998, 29(4):360-372.
 27. Bawah et al., Women's fears and men's anxieties: the impact of family planning on gender roles in Northern Ghana, *Studies in Family Planning*, 1999, 30(1):54-66.
 28. Ibid.
 29. Maman S et al., *HIV and Partner Violence: Implications for HIV Voluntary Counseling and Testing Programs in Dar es Salaam, Tanzania*, New York: Horizons Project, Population Council, 2001, p. 26.
 30. Ibid.
 31. Solo J et al., Creating linkages between incomplete abortion and family planning services in Kenya: what works best? New York: Population Council, 1998, p. 22.
 32. Kim YM and Awaum D, What are the particular aspects of counseling male family planning clients? Case from Kenya, paper presented at the annual meeting of the American Public Health Association, New York, Nov. 17-21, 1996.
 33. Abdel-Tawab N, Huntington D and Nawar L, Ethical considerations in studying the effects of counseling the husbands of postabortion patients in Egypt, paper presented at the annual meeting of the American Public Health Association, Indianapolis, IN, USA, Nov. 9-13, 1997.
 34. Pile J, 1999, *op. cit.* (see reference 12).
 35. Ibid.
 36. Singh K, Bloom S and Tsui A, Husband's reproductive health knowledge, attitudes and behavior in Uttar Pradesh, India, *Studies in Family Planning*, 1998, 29(4):388-399.
 37. Reproductive Health and Research Unit (South Africa) and Population Council, *Men in Maternity. Enhancing Roles and Responsibilities of Men in Women's Health*, Durbin, South Africa: Reproductive Health and Research Unit and New York: Population Council, 2001.
 38. Population Council, Involving men in their wives' antenatal and postpartum care in India, *Frontiers Project Research Update-Mar. 2001*, New York: Population Council, 2001.
 39. Community Aid and Sponsorship Program and Foster Plan International (CASP-PLAN), Working with men to improve reproductive health in a Delhi slum, in: Raju S and Leonard A, 2000, *op. cit.* (see reference 5), p. 26.
 40. Social Action for Rural and Tribal Inhabitants of India (SARTHI), Men's involvement in women's health: the SARTHI experience, in: Raju S and Leonard A, 2000, *op. cit.* (see reference 5), p. 23.
 41. Ibid., p. 22.
 42. AVSC, 1997, *op. cit.* (see reference 14), p. 24.
 43. Ibid.
 44. Ibid., p. 32.
 45. Ibid., p. 30.
 46. Steele C, International Women's Health Coalition, personal communication, Oct. 25, 2001.

Acknowledgments

The author thanks Elaine Murphy, recently retired director of the Women's Reproductive Health Initiative at PATH, for supporting the development of this article, as well as other members of the Men and Reproductive Health Subcommittee of the USAID Interagency Gender Working Group for their guidance. This article is based on a paper presented Oct. 25 at the 2001 annual meeting of the American Public Health Association, Atlanta, GA, USA.

Author contact: Kringheim@path-dc.org