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Transforming Men into Clients: Men's Reproductive Health Services in Guinea

Men's use of reproductive health (RH) services and the local community's approval of and interest in such services rose notably after Guinea's Ministry of Health and EngenderHealth launched an intervention designed to increase access to and stimulate public demand for such services. According to a one-year evaluation conducted at two health centers in Guinea's capital, the number of men visiting a health facility on their own had risen sizably, as had the number who accompanied their wives during RH care visits. Facilities had been revamped to be more welcoming to men, and staff considered themselves better trained to counsel men and to provide them with services. Outreach efforts to inform the surrounding community about men's health needs and about the availability of services for men reached many individuals and were perceived by both clients and site staff to have played an important role in men's increased knowledge about and use of RH services.

Men As Partners® in Reproductive Health

Until recently, facilities that addressed RH issues were generally seen as being for women. As a result, men with RH-related questions or concerns often perceived that they had nowhere to go. Moreover, if clinicians received any RH training, it was usually as part of their training in obstetrics and gynecology; there was no comparable clinical training for addressing *men's* RH needs.

To meet this need, EngenderHealth's Men As Partners® (MAP) program (see box, page 2) developed a curriculum designed specifically to train health care providers in low-resource settings on how to work with men. The curriculum addresses men's RH needs in a holistic way while helping providers work with men more comfortably and competently. The Men's Reproductive Health Curriculum consists of three components: an introduction to men's RH services, a volume on counseling and communicating with men, and a detailed description of how to manage men's RH problems. (More information about this curriculum can be found at http://www.engenderhealth.org/ia/wwm/wwmi.html#Training.)

Local imams served as key MAP messengers.


Photo: Manisha Mehta

The Guinea Intervention

The first section of the Men's Reproductive Health Curriculum introduces participants to the attitudinal and organizational issues affecting the delivery of men's RH services and provides basic information on men's health for all staff who interact with male clients. It was evaluated in 2001 and 2002 as part of a larger project conducted in Guinea, in collaboration with Guinea's Ministry of Health. The MAP initiative was focused on two public-sector health centers in one administrative unit (Kaloum) in the capital, Conakry. These sites, located in the neighborhoods of Boulbinet and Coronthie, serve an adult population of 94,000 in 11 neighborhoods, ranging in size from fewer than 500 families to more than 2,000.

Qualitative research was conducted among men to discern how best to work with them on RH issues. EngenderHealth used this research to craft a program strategy and to assist staff in integrating men's issues into current information, education, and communication (IEC) work, through the creation of messages for men on various RH issues, including sexually transmitted infections (STIs), maternal mortality, and female genital cutting.

A "supply-and-demand" framework was used to meet local needs. In order to improve the *supply* of services, EngenderHealth provided technical assistance to help the two health centers build capacity for delivering men's RH services and to develop a supportive environment for male clients to seek them. Thus, EngenderHealth trained 30 staff members from the two sites on the introduction of these services. Two workshops held with doctors, counselors, health educators, support staff, and auxiliary personnel provided them with an opportunity to address provider biases and needs in the delivery of men's RH services. Using the first volume of the curriculum, the workshops covered such themes as men's sexuality, male anatomy and physiology, family planning, reproductive health, STI and HIV prevention, and sexual dysfunction, as well as management and cost considerations involved in services for men. Additionally, clinic staff consulted with clients on how to develop a more supportive environment for men's services.

In addition, to stimulate *demand* for men's RH services within the community, EngenderHealth collaborated with the Ministry of Health and local partners in a series of special activities. For example, 120 peer educators—young men and women, adult men and women, clinic staff, and religious leaders from the community—were trained in communicating about general RH issues and about male involvement. Also, EngenderHealth brought together IEC specialists from the Ministry of Health, representatives from other nongovernmental organizations, members of the national television, radio, and press, and community members to develop messages about male involvement, STIs, and maternal and child mortality.

Formal IEC campaigns were conducted in Kaloum in June 2001 and January 2002. (Two informal campaigns took place at other times, at the behest of local religious leaders.) Each lasted seven days and included a series of interrelated activities, as follows:

- Groups of five or six peer educators conducted *home visits* to discuss RH issues, including male involvement, with adults, youth, and members of the extended family. Four such visits were made during the project—two during the formal IEC campaigns and two at other times not related to larger IEC efforts.
- Local imams offered *mosque lectures.* Because imams were considered key resources and leaders in the community, at least one from every mosque in the area was involved.
- June 13 was celebrated as *MAP Day* in Kaloum. MAP Day activities included speeches by religious leaders and local elected officials, dissemination of IEC materials, conferences, and special media coverage.
- Finally, during the two formal campaigns, local radio and TV broadcast *roundtables* focused on men's health that involved discussions and debates regarding various IEC messages.

EngenderHealth staff from New York and Guinea evaluated these program activities over a two-week period in October 2002. Twenty-seven in-depth interviews were conducted with clients, providers, and managers at the two sites, as well as with health communication professionals from the Ministry of Health IEC Division. Also, focus-group discussions were conducted with 37 peer educators and 16 religious leaders, to gauge the perceived impact of the peer-education activities on community members' awareness of and knowledge about male involvement in RH issues.

The Men As Partners (MAP) Program

EngenderHealth's Men As Partners (MAP) program works to address the broader reproductive health concerns of both men and their partners. In collaboration with country-based organizations, the program uses evidence-based approaches to help design, expand, and improve services that:

- Educate men so that they know more about both their partners' reproductive health and their own
- Facilitate men's support of their partners' family planning use
- Increase men's responsibility for preventing transmission of sexually transmitted infections
- Encourage men to use contraception themselves
- Increase men's access to high-quality reproductive health services

What Happened?

Supply-Side Achievements

First, staff enthusiastically implemented a number of changes in response to their new perspective on male involvement. Today, a man walking into either site is shown to the Men's Section, an area where services such as general health exams, STI screenings, and fertility screenings are provided by specially designated doctors and counselors. In addition, clinic staff made a concerted effort to provide information about men's health, placing

posters around each site with messages geared specifically to men and providing special educational sessions for men. Finally, site staff took part in outreach efforts with men in the community.

At one site, a doctor commented, "Through the training, we were able to identify specific problems for men in the center. This helped a lot and increased the influx of patients, because awareness is greater about coming to the center." A nurse at another clinic observed that the training "has been very practical. Before I only worked with women…. [Now] I am more knowledgeable about men's illnesses and how to deal with men. It is also very surprising—I did not think it would be easy for them to talk to me or for me to talk to them." Finally, as a doctor at one clinic explained, "Within my community and mosque, people ask me for advice. The training has opened my relationship with my clients. I used to be very nervous…now I put myself in the place of my clients and listen to find a solution. It has changed my relationship with my children as well—I am more open with them." The training contributed to a greater effort to reach potential clients *within* the sites themselves (known as *inreach*). For example, a number of staff mentioned that they now take every opportunity to reach out to men, such as by inviting men who are waiting for their partner to step over to the Men's Section.

One outcome of these efforts has been an increased number of couples who come in together for consultations and treatment. As one nurse-midwife said, "After the orientation campaign, the women did not feel bad about coming with the men. They realized that they should come together as a couple." A male peer educator explained that the training "helped us to think more about the common belief that women should have as many children as possible. Now, it is the men themselves who come to the health center with their wives and request assistance in planning their families…. Women [now] share their concerns with their husbands, and the men are more aware of the risks that women can be exposed to by having so many children." Staff also observed a decrease in the number of repeat STI infections among women, and attributed this change to the number of men who now receive treatment at the same time as their female partners.

Providing services to men goes beyond the practical benefits mentioned here: Having access to these kinds of services facilitates positive attitudinal changes in clients as well. According to clients who were interviewed, a major factor for their seeking services was their reception. One client said, "I was very well received here and because of this, I will continue to come and bring my wife." Another client stated that receiving information about men's health allowed her to "feel a greater sense of involvement" in speaking with her husband.

Information from client registers supports the perception that service usage by men and their partners increased following MAP efforts. At one clinic site, staff reported that before the program began, they saw an average of five or six male clients each month, but client registers indicated that following the intervention the clinic had about 30 to 35 male clients per month. In addition, over the period from January to September 2002, 342 male clients visited the men's sections at the two clinics, about two-fifths the number of female clients at the maternal and child health wings of clinics (846). The registers also showed that 258 (75%) of male clients' visits were for consultations related to STIs.

Demand-Creation Successes

The demand-creation activities alerted community members about both the importance of men's health and the availability of special services for men at the local clinic; as a result, community knowledge about men's health increased and attitudes toward men's involvement improved. Men's constructive involvement in RH practices improved as well: Both female clients and site staff reported observing attitudinal changes among men in Kaloum. One staff member commented that "men are being more responsive to the health needs of their spouses and children," while another noted that "the number of men who accompany their partners to meet with family planning counselors has been increasing." A male client being evaluated for fertility problems commented that "my family had decided to give me another wife because in all of the time I had been married, I had not had children. But because of the information I received at the clinic, I have decided to wait until my wife and I finish our treatment to make a decision."

Efforts to disseminate MAP-related messages had broad success. For example, widespread local interest in the roundtables led to additional free coverage in the local media, and all of the activities in the campaign were showcased on a local television program, *Santé Pour Tous* (Health for All). Moreover, the imams brought key messages to a large audience: Each Friday, especially during the IEC campaigns, the imams gave a lecture on one of the messages developed for the campaigns; on a typical day, they reached approximately 33,000 men and women. One imam commented, "When we were asked to participate in this, I liked the idea of taking part in the work of a group that will help people get healthy."

These efforts led to increased linkages between the community and the service-delivery sites. Men now come with their wives to the clinic seeking assistance in plan-

ning their families, based on the recommendation of or a referral by the peer educators and imams. In addition, peer educators report that since the campaigns, women have begun to talk about their health problems with their husbands, and that as a result a growing number of couples consult them directly. One peer educator stated that "a common feature of African families is a lack of dialogue—women speak about their problems with other women, and men speak about their problems with other men. Since the campaigns, women have shared their problems with their husbands and have sought out peer educators for advice and referrals to the health center."

Lessons Learned

As with most services, interventions to increase male involvement should approach the issue from both the supply and the demand side. For example:

- *Responding to providers' needs is critical to success.* Understanding providers' needs and roles is an integral part of introducing RH services for men. A provider's own comfort with sexuality, his or her own feelings about gender, and previous training all play a role in how he or she may interact with a male client (either as an individual or as part of a couple).
- *Men want to be involved in protecting their health and the health of their partner.* EngenderHealth's experiences in implementing the Men's Reproductive Health Curriculum demonstrate that contrary to popular perceptions, men often wish to be more involved in family planning and RH decision making and are interested in their own health but are reluctant to appear ignorant. In many instances, male clients were encouraged to care for their health once they saw that there were services designated specifically for them.
- *Participation and ownership engender behavior change.* It is important to work with stakeholders from the beginning. Participation and ownership are cornerstones of the MAP pilot project in Guinea. From the start, the Ministry of Health, service providers, community leaders, clients, and local RH organizations (such as the Guinean Association of Midwives and the Coordinating Group for Traditional Practices Affecting the Health of Women and Children) were included in the process. Doing so not only is a way of obtaining their support, but also encourages personal reflection and commitment to adopting a new set of norms.
- *Strategic alliances with the community are necessary.* The support that has been received—and publicly expressed—by members of the local community, including its leaders, has engendered a sense of community ownership. Local imams were an integral part of this process and continue to play a valuable role as information resources. Without their involvement and public endorsement, the project likely would not have been as successful in reaching out to men.
- *Low-cost, simple outreach campaigns work.* For many people—especially men—clinics represent a very small part of their lives. Thus, information and education need to reach potential clients outside as well as inside the clinic setting. The success of the outreach campaigns and home visits proves that going to places where clients spend their time is key to spreading messages effectively.

Overall, the experience in Guinea suggests that peer education and outreach activities are a great complement to capacity-building at a site. Simply making quality services available is not sufficient; potential clients need to be informed about them, and the "word on the street" needs to be positive. Peer education is an essential part of stimulating community interest and can be done with few resources if community members are committed and supportive from the beginning.

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