Addressing Gender Issues with Men and Couples: Involving Men in Sexual and Reproductive Health Services in APROFE, Ecuador

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This article is based on a study of the male-involvement initiative of APROFE (Association for the Benefit of the Ecuadorian Family). It analyzes the lessons learned from a mix of strategies to increase the number of male clients attending APROFE's sexual and reproductive health services. Based on provider interviews, the study describes the gender and privacy issues that arise when treating heterosexual couples in health services and highlights the dynamics between each member of the couple and the service provider in the case of STI diagnosis. The study revealed clear benefits from male involvement—for both members of the couple. At the same time, the limitations of the health service setting in resolving gender issues that underlie sexual health problems are clear from the findings.

Keywords: sexual health, reproductive health, male involvement, gender, sexually transmitted infections, sexual health services

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This article[1] focuses on the male-involvement initiative of APROFE (Association for the Benefit of the Ecuadorian Family). The initiative began in the late 1990s and dovetailed with APROFE's efforts to become more financially sustainable, to improve quality of care, and to increase attention to gender equity throughout its national network of 20 reproductive health clinics in 17 cities.

In the male-involvement initiative, providers systematically encouraged women to bring their male partners to the service. APROFE then used mass media to encourage other men—both individually and in couples—to use APROFE's services. As the number of men using the services began to rise dramatically, health providers were confronted with new issues related to quality of care, gender, and users' right to privacy that had to be dealt with systematically throughout the organization, not just on an ad-hoc basis.

The data for this study comes from two main sources: APROFE documents, mainly monitoring data and gender training program reports and minutes,[2] and interviews conducted by the author in 2000 with providers of all levels at four clinics: 28 semi-structured individual interviews and four group interviews.[3] The clinics in the study represent distinct Ecuadorian cultural areas and clinic sizes, and the gender training team evaluated them all as having a positive response to gender training.

The interview guides focused on providers' experiences with and opinions about gender training as well as examples of how the staff incorporated gender issues into their daily practice. Male involvement and the issues arising during STI diagnosis emerged as a central theme in the interviews; it was not the original focus of the study.

BACKGROUND

With 13 million inhabitants, Ecuador is one of the smallest and poorest countries in Latin America. In 1998, 62.6% of the population lived below Ecuador's official poverty line, and 26.9% were classified as indigent.[4] According to UNICEF statistics for 2000,[5] the maternal mortality rate is 130 per 100,000 live births, and infant mortality is at 27. Recent studies in Ecuador show that the fertility rate has fallen to 3.4.[6] With almost universal primary school enrollment, the literacy rates for adults of both sexes are in the high 90s.

APROFE's experiences with promoting male involvement closely parallel those of the family planning field as it transformed into the field of sexual and reproductive health. From the 1970s through the 1990s, like most International Planned Parenthood Federation's (IPPF) affiliates in Latin America, APROFE concentrated on family-planning services. From 1984 through 1994,[7] most family planning agencies' initiatives on "male involvement" were limited to promoting men's increased use of birth-control methods—condoms and vasectomies—and their decreased opposition to women's use of contraception. Within this framework, APROFE's experiment with a male clinic to promote male family planning methods in the early 1990s did not prosper, leading them to re-think their strategy.

IPPF's "Vision 2000" in 1992 and the International Conference on Population and Development (ICPD) Programme of Action[8] in 1994 provided a new direction for male "participation and responsibility," placing it within the framework of women's empowerment and comprehensive sexual and reproductive health. Men

were to assume an equal role in caring for sexual and reproductive health, in shouldering their fair share of domestic responsibilities, and in promoting equality between the sexes.[9] Downward trends in external funding in Latin America provided an additional incentive for APROFE to reach out to men. By 1995, it became clear that their main donors—USAID and IPPF—would be significantly decreasing their support, and in the case of USAID, would halt aid altogether by the end of 2001. For reasons of economic survival, APROFE had to concentrate on increasing its income by raising service fees and increasing its number of clients. Diversifying services, increasing marketing, improving quality of care, and attracting more men were the cornerstones of the strategy to attract more paying clients. APROFE leadership viewed attention to gender issues as an integral part of its quality of care initiative and as a tool to serve both men and women more appropriately.[10] The marketing strategies were designed to attract men by changing APROFE's public image as a women-only clinic and publicizing new sexual health and urology services. The availability of these services also helped women persuade their partners to come to their next visit. APROFE's Director of Evaluation, Agustín Cuesta, explained in an internal document:

> Involving men in sexual and reproductive health, either through having them accompany women or through having them be users in their own right, makes it possible to ensure their support for women's decisions and helps us keep users coming regularly. [Involving men] also means that we can attract a population that has never come to our services before.

As Cuesta suggests, these strategies succeeded both in attracting more users overall and in dramatically increasing the number of male clients so that APROFE's push toward self-sufficiency has been very successful. As of February 2003, the organization survives mainly on service fees.[11] Unfortunately, the loss of external support affected the user profile, which includes fewer low-income clients than before.

In summary, these strategies not only brought about greater sustainability but also helped the institution incorporate the principles endorsed at ICPD, such as commitment to gender issues and to a more comprehensive sexual and reproductive health framework.

OBSTACLES TO MALE INVOLVEMENT

Numerous obstacles to male involvement are documented in the literature and also in this study. Perhaps the best-known obstacle is that professionals in reproductive health recognize that it is more difficult to get men to use reproductive health services than it is to get women into a clinic.[12] The reason for this gender-based discrepancy is that men are less willing than women to admit that they are ill or to take care of their health in general.[13] Often men will seek medical care only when their illness has advanced to the point that it is difficult if not impossible to treat. This behavior is apparently based on the expectation that men are not supposed to show weakness or to complain about pain.[14] One APROFE doctor commented:

> Men do not like to go to the doctor or to be sick, because for a real macho sicknesses do not affect them. It is part of the patriarchy and ancestral customs. For this reason, a man will not come to see a doctor until he is really badly off, at which point it may be too late to help him.

Male discomfort in the submissive role of the "patient" may be so pronounced that often when wives accompany their husbands the husband is silent and the wife does all the talking, which is the reverse of the more common pattern of conversations being male-dominated.[15] To avoid what they consider the demeaning experience of going to a doctor, men tend to self-medicate in pharmacies following their friends' or pharmacists' advice, a practice that often fails to address their health problem appropriately.[16]

Other logistical and sociocultural barriers can hamper male involvement. For instance, clinic hours often need to be adjusted so that men who work full-time or more can make their clinic appointments without jeopardizing their livelihoods. Also, according to APROFE providers, men sometimes care for the children so that women can visit the clinic.

Once men arrive in the clinic, other sociocultural barriers arise. APROFE providers observed that male stereotypes perpetuated by providers as well as female partners can create an obstacle to men's involvement. APROFE's gender training program had to overturn providers' long-held assumptions about men's unwillingness and disinterest. Providers must then work with women's assumptions. Low expectations are self-fulfilling when they lead to failure to invite men to services.

> Sometimes the woman anticipates his response and says, "He won't want to [come to the clinic]." We assume that he is machista, but maybe he isn't, and we are just prejudiced. [Sometimes] when we [finally] talk with the male partner he says, "See, I told you that I could help out." However, there are also cases of men who are much more resistant. Maybe in the clinic they seem to accept our advice, but once they leave, they don't. (Clinic supervisor)

Furthermore, men's traditional roles make them less willing to put up with disrespectful treatment or other problems with quality and less willing to tolerate the hierarchical nature of the doctor-patient relationship. APROFE conducted both a male focus-group study[17] and user satisfaction studies that pointed out the need for a serious quality-of-care initiative because clients who were paying higher fees and men of all economic classes would not use the services unless quality of care improved.

Finally, of course, women get pregnant and men don't, which reduces men's perceived need for sexual and reproductive health services. In light of all of these obstacles, strategies to attract men must be multifaceted, emphasizing the importance of their and their partner's health.[18]

FROM MALE CLINICS TO MALE INVOLVEMENT

APROFE's first efforts to involve men in the early 1990s corresponded to several experiments with male clinics in the IPPF/WHR network. As in several other countries, APROFE abandoned the experiment after two years; the clinics were under-used and extremely costly per person served, in spite of all their marketing efforts.[19] APROFE's directors decided that they needed to better understand men's knowledge of and attitudes toward sexual and reproductive health as well as their views on sexuality, on APROFE's services, and on how they wanted to be served. APROFE's male focus-group study took place in six cities in Ecuador, differing by size and by cultural region, including low-middle-income and middle-income men. The results provided important information about male patterns of sexuality, including acceptance of multiple partners, a period of high risk before marriage, and sexual and physical violence against women. Men would not inform wives of an STI diagnosis and were unwilling to use condoms or have vasectomies. They expressed no preference for male-only services, as long as they were treated well and received high-quality service.

These results pointed to simple changes in providers' behavior—in reception areas and in counseling—to make men feel welcome and to help dispel the perception that APROFE's services are for women only. With this orientation on how services needed to adapt and improve in order to serve male clients, APROFE began its concerted efforts to attract more male clients, while the findings from the study informed intensive training in quality of care and in gender issues institution-wide.

APROFE'S CURRENT MALE INVOLVEMENT INITIATIVE: SUCCESS IN ATTRACTING MEN TO CLINICAL SERVICES

APROFE used three strategies to attract more men to its clinics:

- Standard protocols for providers mandated that they encourage female users to involve male partners. The first directive to all personnel was in 1998, but the invitations in many of the main clinics started in 1997.
- Radio campaigns advertising that APROFE provided services for both men and women began in 1996, with little effect. Beginning in 2000, however, urology services were advertised on both radio and television.
- Clinic hours were adjusted to men's schedules. In big cities, all APROFE clinics see patients on Saturdays, and many have extended their weekday hours until 7 p.m.

These strategies have proven successful. From 1999 to 2000, the clinics in this study doubled the number of users who are accompanied by their partners from 545 to 1,121 on average per month.[20]

In Guayaquil, between 2000 and 2001, the average number of users accompanied by partners increased by 74%, whereas the total number of users increased only 11%.[21]

Using urology visits in all APROFE clinics as the other main indicator for male usage, the number of male users has steadily increased since 1996, with a notable

Table 1
Average Number of Visits per Month to Five Guayaquil Clinics

	Jan.-June 2000	Jan.-June 2001	Increase	Percent change
Couples	1,627	2,828	1,201	+74%
Individuals	14,573	16,209	1,636	+11%

Note: Table constructed by author from APROFE statistics

increase of almost 3,000 male users in 1998, when the first directive to APROFE providers went into effect to encourage female users to invite their male partners. This sharp increase clearly supports APROFE's hypothesis that spousal encouragement was the main initial factor responsible for the significant increase in men's clinic visits. Another above-average increase of more than 2,000 male users occurred in 2001, when APROFE increased its mass-media marketing of urology services. In other words, after APROFE had established a stable base of male clients and solidified its public image as providing care for both sexes, then mass-media advertising played a greater role in attracting men.

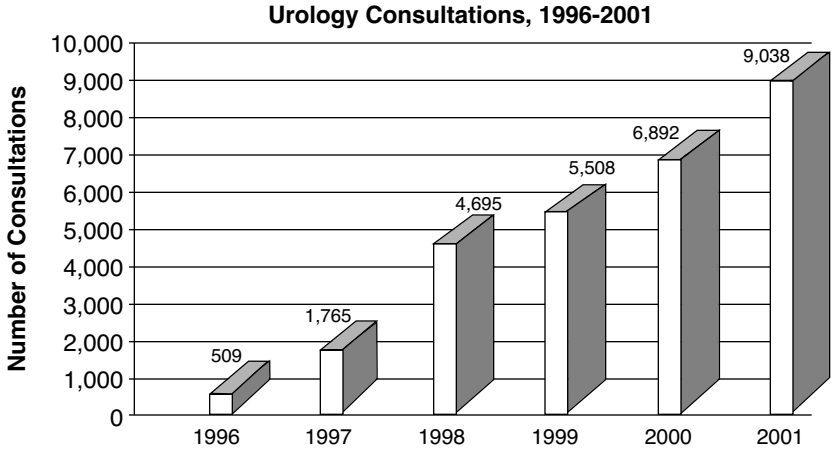

Figure 1. Yearly increase in urology visits at APROFE Clinics: 1996–2001.

Note: Figure constructed by author from APROFE statistics

However, attracting men to its clinics presented APROFE with many issues: How do gender issues manifest themselves when both male and female partners are involved? Difficult questions arise in the process of "mainstreaming gender issues," which should include a policy of zero tolerance for abuse of women's rights, when

serving those men who abuse their female partners. Is it possible to halt men's abuse of power while promoting the rights and well-being of the men being served? How do providers deal appropriately with couples whose relationships are characterized by the traditional male-female roles of domination and subordination? Can services help men deal with the aspects of male gender roles that put men at risk? How can the right to privacy of both men and women be protected?[22]

APROFE's experiences in protecting an individual's right to privacy and confidentiality and encouraging involvement of both sexual partners are instructive. Mainly, its efforts had focused on ensuring women's right to privacy; but when its providers began treating men, they realized that men's right to privacy was just as crucial, especially in regard to STIs. APROFE's providers found that close teamwork and clear communication among clinic staff were necessary to protect privacy, and Information, Education, and Communication Department (IE&C) staff used training and supervision to continually reinforce the need to adhere to clinical protocols that mandated getting women's consent before involving her partner. Providers have had to be creative in finding ways to ascertain privately whether a user wanted his or her spouse present at each stage of the clinic visit.

Many APROFE providers who have been confronted with such dilemmas have found ingenious ways to resolve the presenting health problem, thus meeting both women's and men's short-term practical needs. Is it possible for providers to take the next step of addressing underlying gender inequities.

The following section takes an in-depth look at the situation of couples receiving STI diagnoses as a window into the lived reality behind these questions.

APPLYING GENDER FRAMEWORKS AND INVOLVING COUPLES TO PREVENT AND TREAT SEXUALLY TRANSMITTED INFECTIONS

The distinction between meeting practical interests versus strategic interests is useful in considering the application of gender frameworks in sexual and reproductive health programs.[23] In gender theory, practical interests are related to material problems, such as an STI diagnosis, that have a short-term solution but may arise from gender inequities and gendered sexual norms. Strategic interests are related to the root causes of these short-term problems, often gender-related inequities, sociocultural norms, and discrimination.

In most cases, APROFE providers reported successfully involving men in preventing and treating STIs[24] but offered few examples of interventions that addressed power dynamics within the couple that block communication and thus make it more difficult to prevent and treat infection. Using the gender lens, curing a STI serves both the man's and the woman's practical interests. Following standard guidelines, APROFE's staff focused on involving men sufficiently to cure the infection; possibly the information they provided would prevent future infections, but this was not a given. Curing an infection by treating the couple was an important advance over treating women only—an advance in which the providers justifiably took considerable pride. However, without addressing the gender dynamics at the root of the infection, the couple's strategic interests were not served.

One obstacle to addressing strategic gender interests shows up clearly in this study: diagnosing couples with STIs created emotionally charged situations for both the couple and the provider. The short time period of the typical clinic visit made it imperative that the providers concentrate on providing information and treatment and not on the counseling that was needed. Furthermore, most providers in such clinics are biomedically trained professionals with limited training in counseling, and the demands of the situation usually exceed their level of preparation. In the larger APROFE clinics, their teamwork with the intake counselor or with the in-house psychologist (in two of the large clinics) was an essential part of APROFE's services.

APROFE's Standard Approach to STIs

How can biomedical professionals be trained to handle the stress and emotional issues that arise after diagnosing an STI? APROFE promotes strategies that discourage mutual blaming and encourage focus on treatment. In this manner, they report that they are able to treat most couples for STIs, thus addressing women's and men's immediate interests.

One of the first issues that APROFE's quality of care and gender training confronted was providers' tendency to withhold the diagnosis of an STI from a user, fearing an emotional reaction.[25] This doctor described some of the deficiencies of treating STIs before gender training was offered:

> Before we tended to conceal some of the facts about STIs, but they taught us in the gender course that full factual disclosure is important. For example, we have to say that the [symptoms of] herpes or condiloma [HPV virus] can get better, but there is no cure. Sometimes this scares people. (Doctor)

The gender-training course and the follow-up training team have helped providers follow a standard practice for dealing with STIs, which is to disclose all the medical facts, focus on the cure, and move ahead with treatment. "Let's not focus on who is to blame" was the refrain APROFE providers used when speaking to couples who have been diagnosed with STIs. Ideally (as in the next example), the provider recognized when the couple needed help to deal with the emotions provoked by the diagnosis and offered to refer the couple to a psychologist or intake counselor who has been trained in psychology or social work.

> I would like to point out . . . conflicts when we try to apply gender perspectives in cases of STIs. The woman asks me, "So, the transmission is solely sexual? So he gave it to me?" I respond, "I can't say that. We are not here to place blame; this is a disease within the couple. Talk with him." There are men who admit that "I [might have gotten infected] in that place," but rarely will they say this with their partner present. Then I give her informational pamphlets…. This is when integrated teamwork is so important. They

> have the option of returning to the intake counselor, because this is difficult; it is a shock for the patient and for the couple.... I have to tell them that it is an STI, but that there is a solution [this is a case of a curable STI].... I encourage them to focus not on the problem but on the solution. (Doctor)

Naturally, the standard procedure does not always work. Furthermore, the clinician may not have the time or the opportunity to address the underlying sociocultural causes of infection, thus requiring a professional trained in counseling and gender issues to be available for the important follow-up sessions. However, most small clinics do not have personnel who are trained to deal with these sensitive issues and need to establish referral networks.

CASES IN WHICH MALE INVOLVEMENT IS NOT POSSIBLE

In some couples, the woman does not consent to involving her partner because of the man's dominance and mistrust and/or her fear of her partner's aggression, making male involvement impossible. The dynamics of the couple's relationship are too unequal and fear-ridden to allow proper medical treatment, which means the infection cannot be eradicated. These cases clearly illustrate how gender-related power inequalities within couples pose important obstacles to preventing and treating STIs. When a woman is so fearful of her husband that she does not dare tell him the diagnosis, how can this and future infections be treated and prevented? The following anecdote exemplifies these gender dynamics.

> Many times when women come alone and we diagnose an STI, we explain the situation to them, and they prefer to say nothing to their spouses . . . because their husbands are aggressive, and they will think that the wives have had sex with other people. The women prefer to keep silent and treat themselves with herbal remedies, waiting until the men realize that they are infected and seek treatment. (Doctor)

In this case, the woman does not know whether her husband is treating himself and whether she should treat herself simultaneously. With so much fear and so little communication, the couple will just keep reinfecting each other, yet APROFE providers must respect the woman's decision. If she does not want her husband to know, they can do nothing except point out to her the medical consequences of her decision. These dynamics are also a clear signal of violence in the relationship. Unfortunately, the follow-up to APROFE's gender training program did not deal adequately with this issue.

In cases such as these, the only way to involve men may be to offer a community education program on sexual and reproductive health issues that includes STIs and addresses gender issues with a special emphasis on violence against women.

MEETING PRACTICAL BUT NOT STRATEGIC GENDER INTERESTS

Several anecdotes illustrate both the benefits and the problems with men's involvement in sexual and reproductive health services, where it is difficult to address strategic gender interests in relationships characterized by male dominance and sometimes violence. The provider below and several others worked within the limits of a patriarchal system by using their authority to convince the male partners of the importance of following the doctor's orders, especially when these involve abstaining from sex. At least three doctors in the study found male partners so difficult to convince of the infection's severity that they had these men look at their partners' infected cervix. In these cases, the doctor's power and legitimacy made the treatment work, because the woman did not have enough power in the relationship to convince the man to comply with treatment. The doctor's authority provided the only way to correct the power imbalances within the couple during the clinical visit. Then, once the man was convinced, he usually became involved and complied with the doctor. However, one account alerts us to the risk that the man might also assume control of the woman's treatment, removing all agency from her.

> When we have found cervicitis and lesions and given treatment with cauterization, we have had problems when we tell a woman that she cannot have sexual relations for a month. . . . When we see that the spouse does not understand, we invite him in to explain the condition. . . . If the woman consents, we have him come into the examining room so that he can see the cervicitis and see that when his wife complains of pain during sexual relations, it is not because she doesn't want to have sex with him or because she no longer loves him, but because she is physically sick. He sees the lesion, and the situation improves, because he begins to participate in her treatment and makes sure that she takes her medicine and comes in for her follow-up visit. . . . [They come to follow up and he says,] "Here, doctor, I've brought her in; check her to see how she is, to see if everything is all right." (Doctor)

This situation is better than the one in which the levels of fear and mistrust are so high that the man cannot be involved at all. In this case, the man was actively involved in promoting his partner's health and in the process protected his own as well. The infection could then be cured when previously it could not. However, the woman still had little protagonism or power in protecting her health or the couple's health. She still needed the doctor's legitimacy to do this for her, and then her male partner took control of her treatment.

Gender roles, users' rights, sexual rights, and cultural taboos are all raised when diagnosing and treating an STI. In the following example, in which the man was participating in the clinical visit but not in the physical examination, the provider was able to understand the causes of an intractable infection only after the woman confided in him privately (i.e., "behind the curtain"). The midwife then had to figure out

how to deal with the man's denial of his sexual practices that were causing the infection and with the power dynamics that made the woman unable to refuse painful sexual practices. Undeniably, these complex and sensitive situations are very hard to address in the limited time of a clinic visit.

> I had one patient who had terrible [vaginal] infections that did not respond to treatment. One day I asked them about anal sex, and the husband answered, "No, we do not do that." But then the wife told me behind the curtain, "Yes, we do that, and I don't like it. Please tell him that I don't want to do that." Well, I could not exactly say that, but [after the examination] I said to both of them that if by chance they ever had anal relations, this and that could occur, and it would be another reason why the infection could not be cured. I had to convince him indirectly. (Midwife)

This is another example of dealing with practical gender interests—the immediate problem—without addressing strategic gender interests. Although the woman has not gained any more power to protect her own health or rights in this relationship, the provider can intercede on her behalf so that she will no longer be subjected to a sexual practice that she dislikes, and her infection will be cured.

As mentioned previously, serious conflicts often arise with this diagnosis. One strategy that averts such conflicts emerged from interviews with providers. In this strategy, the providers suggested that one member of the couple—usually the husband—may have contracted the infection before the marriage. One clinic supervisor remarked, "I try to explain that maybe she is infected because her husband had a relationship before marriage and that the symptoms are only appearing now."

Especially for younger couples, this convenient "excuse" may actually be true. The advantage of this strategy is that it minimizes tensions, thus allowing the couple to comply with treatment.

While the convenient maybe-it-happened-before-marriage strategy may simply be sacrificing strategic interests for practical ones, on closer analysis the relative costs and benefits are not so clear. If the infection was indeed contracted prior to marriage, the provider is acting responsibly and helping to minimize conflict by offering this possibility. However, this strategy does not encourage couples to communicate frankly and may leave one of them with lingering doubts about whether the STI was due to infidelity. Such doubts can later poison the relationship. In addition, the strategy does not directly address the gendered double standard within marriage that permits men to have multiple partners but does not tolerate such behavior in women. In many cases, however, in the interest of keeping their relationship positive and offering the benefit of the doubt, both members of the couple may prefer this possible explanation. If the diagnosis and subsequent counseling gives the man (or the woman) enough of a scare and enough information to prevent future infections, at least their future sexual health has been protected.

ADDRESSING BOTH STRATEGIC AND PRACTICAL GENDER INTERESTS

APROFE's experiences suggest that the STI clinic visit proved to be a difficult context in which to promote strategic gender interests. When such strong emotions are involved, most providers' efforts may go to trying to contain them—within the limited time frame available—so that the couple can take responsibility for treatment and future prevention.

A few providers trained in psychology or social work—such as the following intake counselor—reported positive experiences in which they could successfully address both gender and sexual health issues.

> Generally, providers send couples back to me when a homemaker is diagnosed with an STI because this creates a conflict within the couple. I explain that the infection may have been dormant for years [author's note: again, the convenient explanation] but I also explain that men . . . have been socialized and pressured to have sexual relations with no protection. This is how I introduce the gender focus so that they do not focus on blaming the other, but rather on treating the illness. This helps unite them because they come together for the treatment. (Intake Counselor)

This counselor was directly alluding to the sexual health risks caused by socialization of men, which pressures them to be sexually active and to take risks. She presented this information in an effort to defuse the anger of a woman who was diagnosed with an STI and to keep her from assigning blame. The counselor implied that after talking with the woman the next step was a joint visit for treatment. Ideally this second visit would include a counseling session for the male partner to discuss the health risks associated with male gender norms encouraging multiple partners. The crucial step, then, in addressing strategic gender interests is to begin to educate users on how traditional gender roles augment their health risks and to urge them to consider changing their behavior. This could be accomplished through a follow-up visit to a counselor and through a variety of educational interventions in the clinic and the community.

MAINSTREAMING A COMMITMENT TO GENDER EQUITY: CLINICAL AND COMMUNITY-BASED STRATEGIES

The study of the gender-training program in APROFE illustrates that incorporating a gender-based framework required a three-step process.[26] The first step is to accept that gender roles are socially constructed and not innate. Typically, this is the first educational goal of gender-training programs and the essential base for any further training on the subject. Interviews with many APROFE providers gave ample evidence of their awareness of this key principle. The second step is to understand the epidemiological aspects of gender roles, i.e., those that pose risks to health. To this end, the IE&C Department has constructed protocols of gender-related health risks for training purposes. Several providers were able to discuss some of these risks and

provided examples of using them in their counseling.[27] The final and most challenging step is to actively promote gender equity with male and female users and within the communities served. Being aware of inequities and their relationship to health risks is one thing, but working actively to end gender inequities is a step that most health services do not take. For APROFE and most organizations worldwide, community-based advocacy and education is the next step in the gender-mainstreaming process and one in which it is important to involve both men and women.

This study illustrates the many constraints of healthcare providers in dealing with gender issues. They are not trained to provide in-depth counseling on highly emotional issues. They often have lines of users waiting to see them, so that spending more time than usual with one person may serve that user's or couple's interests at the expense of several other users. The provider is only one actor in a person or couple's life, and usually a minor one. Finally, there are many socioeconomic structures and dynamics related to reproductive health, sexual health, and gender inequities over which providers have no control and which put members of the community at high risk for sexual and reproductive health problems.

Yet, within this limited sphere of influence, health providers have an important opportunity to be a positive influence in an individual's or a couple's life. This study gave some examples of how providers can intervene to promote gender equity while counseling clients.

One doctor stood out for her grasp of common gender issues behind sexual problems reported by women.

> Many times we see patients with sexual problems who . . . think that the cause is physical, when in fact we find that the sexist customs within the couple cause her to submit to sexual relations when she has no desire to do so. . . . Using a gender focus we help her to understand that she can say when she feels desire and when she does not, whether due to some physical cause or being tired from housework. We invite her spouse so that we can explain to both of them the importance of equal participation in the sexual relationship. The women complain that they have never had an orgasm and tend to think that they are at the root of the problem, when actually their partners are not helping them [to get excited].

Besides face-to-face interventions, other important educational interventions to promote gender equity within the clinic setting include the availability of brochures on gender-related subjects, videos and talks in the waiting room, and posters on the walls.

Due to all the sociocultural obstacles to male involvement in clinical health services discussed above and to the limitations of the clinic setting, effective prevention efforts in sexual and reproductive health are best served by complementing service-related strategies with community-education strategies, whether through media campaigns, direct community outreach, or both. While services can play an important part, outreach to men within a community is always an important part of any effort to promote gender equity as well as sexual and reproductive health. APROFE recognized this need for complementary community education; in 2001, they reached more

than 2,000 people in Guayaquil alone with workshops on a variety of gender issues, including women's rights, violence against women, and gender issues and health.

Other ways to promote gender equity within a community might involve participating in advocacy for women's rights or establishing joint educational programs with the local schools, thus reaching male and female youth. Investment in such community-based health promotion and advocacy is an important indicator that an organization is not just paying lip service but is truly committed to promoting gender equity.

In summary, although a clinic visit can be an important short-term intervention for curing an infection and delivering information to prevent recurrences, long-term results require sexual- and reproductive-health services to distribute information about preventing STIs throughout the community and within the services themselves. All messages should discuss those aspects of both male and female gender roles that put people at risk, which would also help promote gender equity and address some of the root causes of people's vulnerabilities.

CONCLUDING THOUGHTS

Agencies that successfully attract men to their sexual- and reproductive-health services face important challenges in regard to promoting gender equity. APROFE's providers found that in treating couples patterns of male domination can silence women, and providers have to use great creativity to protect the privacy of each individual and great tact so that a woman can express her point of view and provide other information without discouraging the man's participation. Conversely, when a man is ill, he may be reticent, believing in the stereotypical attitude that men should not be weak or sick.

This study illustrated the stresses that arise for providers and couples alike when addressing sexual health issues and involving couples. Strong emotions in response to an STI diagnosis complicate treatment. Key constraints are the limited time of a clinic visit and health providers' lack of training for dealing with such emotionally charged situations. APROFE's protocols made the best of a difficult situation but at the time of the study needed improvement in order to address instances of suspected violence against women and to incorporate HIV/AIDS prevention into counseling and referrals of STI clients.

Males' use of sexual- and reproductive-health services creates new situations, challenges, and dilemmas. The main challenge is to involve men while maintaining a commitment to gender equity and users' rights. Precisely because gender equity practices run counter to accepted sociocultural norms, progress is necessarily uneven within any given institution—some staff are more receptive than others, constant reinforcement is necessary, and ground is lost with staff turnover. Therefore, one-shot training interventions do not produce the desired result. Providers need regular training and supervision mechanisms first to understand and accept gender differences and then to understand the different problems men and women have as well as the risks that arise from their gender roles. APROFE recognized this need, and after the gender training the IE&C team carries out technical follow-up visits to half their clinics each year; these visits provide in-depth coaching on quality of care and gender issues.

Finally, the culture of an organization needs to incorporate a commitment to promoting gender equity at every opportunity. Without ongoing training and supervision to reinforce this transformation in the culture of an organization, countervailing cultural tendencies will erode the gains of gender training programs.

NOTES

1. The article is based on Shepard (2003)—a longer working paper on incorporating reproductive health principles and gender issues into APROFE's program. APROFE is the affiliate in Ecuador of the International Planned Parenthood Federation's Western Hemisphere Region (IPPF/WHR).

2. APROFE documents that describe meetings and events related to the gender-training process were written by the Director of Evaluation, Agustín Cuesta, and the members of the Information, Education, and Communication (IE&C) Department, which consists of four professionals and one assistant who are in charge of all training and professional development within the organization. The director of the department is Miriam Becerra, and at the time of the study the other members of the IE&C staff were Abigail Carriel, trainer; Aurora Contreras, psychologist and trainer; Maria Quindé, psychologist, trainer, and coordinator of a community-based program for youth and women's development; and Vanessa Arica, administrative assistant. This study interchangeably refers to the "gender training team" and the "IE&C team."

3. The author interviewed members of the IE&C department in charge of the gender training, APROFE authorities, and a range of providers—from clinic supervisors and obstetrician/gynecologists to nurse's aides and receptionists—at four of the clinics where gender training took place in the cities of Machala, Cuenca, and Guayaquil (Alborada and Mapasingue). One of the group interviews was with three female doctors from three different clinics. The interviews took place during a 10-day period in July 2000 and were transcribed by Graciela Fort-Magnon and Elena Aguila and coded/organized into themes by Doreen Montag.

4. Programa de las Naciones Unidas para el Desarrollo (2001), 12. Many observers believe that these1998 statistics have worsened since the severe economic crisis in 2000. The economy was dollarized just before the study visit.

5. Data retrieved from the UNICEF "Child Info" Web site on February 10, 2005, for maternal mortality (http://www.childinfo.org/areas/maternalmortality/countrydata.php) and for infant mortality (http://www.childinfo.org/cmr/revis/db1.htm).

6. Preliminary results of the 1999 demographic survey ENDEMAIN conducted by CEPAR. Retrieved September 2000 from http://www.cepar.org.ec/documentos/ende99.pdf.

7. The decade between the International Conference on Population and Development (ICPD) in Mexico City in 1984 and the ICPD in Cairo in 1994.

8. Programme of Action Paragraphs 4.24 – 4.29. Report of the International Conference on Population and Development, 5-13 September 1994, UN Doc. A/CONF.171/13.

9. These paragraphs in the Programme of Action stimulated much attention to the subject of male participation in the sexual and reproductive health literature and

among national and international agencies. See Web site retrieved February 10, 2005, (www.rho.org/html/menrh_bibliography.htm) for a comprehensive annotated bibliography of literature on the subject.

10. Miriam Becerra commented that APROFE's IE&C staff noted instances of inappropriate colluding with traditional patriarchal male roles by staff in attempts to persuade men to use male methods of contraception.

11. IPPF continues to support APROFE but at a much lower level than previous years. In 2001, APROFE received a $100,000 grant from the William and Flora Hewlett Foundation, channeled through IPPF, to open an adolescent program. They plan to continue the program on their own resources when the grant ends in July 2003.

12. See Robey & Drennan (1998), 16.

13. INPPARES views this as the major obstacle to attracting clients to their male clinic. Personal communication, Angela Sebastiani, October 2002. See also Best, 1998, 37; Claux, 2001, 8-9; Green & Pope, 1999; Sanhueza, 2001, 1.

14. See Greig et al., 2000, 22.

15. Health providers interviewed by the author both in APROFE and in Profamilia, Colombia, spoke of this tendency.

16. Interviews with Agustín Cuesta, APROFE, and Alfonso López Juarez, Executive Director of MEXFAM. Best (1998) also refers to this problem.

17. See Cuesta (1998).

18. See Wegner et al., 1998, 32.

19. Shepard (2003) discusses the experience with male clinics in APROFE and several other IPPF affiliates in Latin America.

20. Comparing the five-month periods from January through May in 1999 and in 2000. Statistics provided by the Evaluation Department of APROFE.

21. From statistics provided by the evaluation department, APROFE. These statistics correspond to the five Guayaquil clinics.

22. Shepard (2003) provides a full account of how involving couples presented challenges to the services with regard to guaranteeing the right to privacy and how the services addressed these challenges.

23. This is a standard theoretical construct in gender theory, first advanced by Molyneux (1985). Moser (1993) built on this contribution and standardized it into the "Moser framework."

24. At the time of this study, APROFE did not offer HIV/AIDS testing or counseling, and in the interviews there was no evidence that providers routinely referred those testing positive for STIs for HIV testing. Such users should be informed that they are at risk for HIV/AIDS.

25. Social science researchers on medical ethics in Latin America have found that doctors' tendency to "spare the patient" by not fully disclosing unpleasant diagnoses is very widespread, especially with diagnoses of fatal or incurable diseases. Author's notes from meeting at CEDES (Centro de Estudios del Estado y Sociedad, in Buenos Aires) with social scientists and ethicists in mid-1990s.

26. A separate draft chapter on APROFE's experiences in gender training was not included in the final working paper cited in note 1 but is available from the author as a working draft.

27. This study took place in the initial stages of mainstreaming these concepts, before APROFE's IE&C Department had disseminated their protocol, so that awareness of these concepts among the providers was uneven.

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