Changing Women and Avoiding Men

Gender Stereotypes and Reproductive Health Programmes

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1 Introduction

Women have for many years been the focus of international family planning and reproductive health programmes. Services involving men have been sparse, whether as women's partners or as clients themselves, a function of a view of men's roles in reproductive health as peripheral or at least problematic. Though men are increasingly being 'involved' by reproductive health programmes, this view of men as peripheral and problematic on the margins continues to shape programmes. This analysis of research on family planning and reproductive health shows how research and programmes have together reinforced a limited view of gender roles and have thus constrained the ways in which men have been treated by reproductive health interventions. The article ends with some suggestions on how to avoid reinforcing gender stereotypes when involving men in reproductive health and other programmes.

Family planning and reproductive health programmes form the cornerstone of international population policy. In the pursuit of demographic objectives, an emphasis on long-term contraceptive methods for women often overlooked social circumstances in which women make 'choices' about birth control and the gender dynamics that prevent them from making the best decisions about their own lives. While women alone had been held accountable for excessive childbearing, anthropological literature increasingly showed the locus of decision making to reside, not in women alone, but in couples, families, and communities. The HIV/AIDS epidemic also called attention to men and sexuality, which required demographers to look more closely at partnerships and gender roles. These critiques led to the reformulation of population policy reflected in the 1994 International Conference on Population and Development's (ICPD) Programme of Action.

1.1 The formulation of reproductive health policy and its treatment of men

As mortality rates declined and growth rates soared in developing countries in the 1950s and 1960s, population control was identified as an issue of importance to national development and international security. Family planning was identified early on as the principal means of carrying out national

population control programmes, and women as the clientele: if women's fertility could be reduced, population growth could be checked. Government and international donor emphasis in population programmes was on contraceptive prevalence and a couple of years of protection. Long-term methods like sterilisation, the pill, and the IUD were seen as contributing most reliably to the achievement of demographic goals.

In the name of demographic goals, however, women were not always best served. Long-term methods of contraception were vigorously promoted, often through targets, and often with insufficient physical or verbal examination of female clients, or sharing of information about side effects and efficacy. The social circumstances in which women made 'choices' about birth control were largely disregarded, and the gender dynamics that prevented them from making the best decisions about their own lives were not addressed.

The shortcomings of international family planning programmes bred criticism from many quarters, especially from women's advocates and people concerned with the limitations of traditional family planning. While women alone had been held accountable for 'bad behaviour' (excessive childbearing), anthropological literature increasingly showed the locus of decision making to reside in units larger than individual women (in couples, families, and communities). The HIV/AIDS epidemic called attention to men and the spread of Sexually Transmitted Infections (STIs), and demographers were drawn to consider sexuality, which required looking at partnerships and gender roles, often for the first time.[1]

These criticisms contributed to the holistic, social-change approach to population stabilisation articulated in the Programme of Action of the ICPD. This new vision requires that family planning programmes not be the sole means through which population policies are implemented and countries try to achieve their demographic goals. Multi-sectoral policies promote fertility decline by shaping people's decisions about reproduction and sexuality, and by enabling women and men to become more equal partners in reproduction and child rearing, while at the same time fostering broader social goals. The Programme of Action unequivocally links sexual and reproductive health to the gendered values and norms that shape health. It identifies the *enabling conditions* that make individual choices and negotiation with others possible and permits the exercise of sexual and reproductive rights. Population policies, therefore, require coordinated efforts across multiple sectors, including health, education, agriculture and employment, to address gender biases and the context of these rights.

Gender inequities inhibit reproductive health, particularly women's; and men's central roles in determining women's social position and reproductive health are increasingly accepted. Less widely understood is that sexual and reproductive health itself reflects culturally informed notions of gender. The ICPD acknowledges this by mandating that reproductive health programmes contribute incrementally to gender equity and the transformation of men's and women's social roles.

Still, many players in the family planning and reproductive health field have interpreted the ICPD Programme of Action merely as a guide on 'how to do family planning better', and the understanding of gender inequity that shaped ICPD thinking is not integrated into most reproductive health programming. 'Respectful and harmonious partnership', 'sensitivity and equity in gender relations': the programmatic implications of these go beyond much male involvement work. Underlying the reluctance to promote women's rights within programmes are two basic fears: the first, that directing family planning at men as well as women will diffuse the impact of reproductive health policies on fertility decline; and the second, that men will resist having social change thrust upon them in 'culturally inappropriate' ways. By nodding to the status quo, this latter position implicitly accepts men's power and women's subordination.

2 Images of Men in Demographic Research on Fertility and Family Planning[2]

Research is fundamental in buttressing policies and programmes, as it reflects, reinforces and validates assumptions about men's and women's roles by making them 'scientific'. For years, men scarcely appeared in demographic research on reproduction;

when they began to appear, they were likely to be two-dimensional villains, the role allotted them by women-centred family planning programmes. Even now, as programmes search for new ways to involve men, they remain bound by these suppositions. The point here is that these suppositions have been normative rather than transformative; and rather than pointing to needed changes, they have sidelined men.

2.1 Men had been disregarded in demographic research

Men have had a low profile in demographic social science research on reproduction. Demographers have justified the exclusion of men from their research by pointing to the ill-defined span of men's reproductive lives, their assumed inability to report on their progeny, the unlikely chance that they are at home to be interviewed by a survey taker, and the frequency with which children end up in the custody of their mothers at the end of a marriage. Polygyny, serial relationships and extramarital partnerships further dash any hopes for tidy, lasting pairings that would facilitate analyses based on data from men.

The tendency to generate *cross-national* rather than *cross-cultural* data has also limited demographers' focus to broad categories that make generalisations possible and has promoted the broad application of strong assumptions about men and women. Perhaps most important for this discussion of male involvement, however, is the strong bias towards a western model of the family, which powerfully limited demographic conceptualisations of the issues, and therefore of data collection and analysis. Through the establishment of international family planning programmes funded by developed nations, these assumptions about gender roles were propagated all over the developing world. The demographic accounting system for biological phenomena like births and deaths was not principally concerned with explaining why these things happened the way they did. Frozen within this accounting system were strong assumptions about women's (primary) and men's (secondary) roles in childbearing, and the consonance or basic sameness of the views of husbands and wives.

A primary assumption about gender roles has been that men are economically important yet contribute little more than a desire to furnish sperm, manifesting a disinterest in – or active objection to – contraceptive use. As is argued elsewhere, 'modernisation [theory] and the New Household Economics share similar understandings of men and women ... Men work outside the home, whereas women are responsible for activities associated with the production of children and domestic services' (Watkins 1993:561). By holding women entirely accountable for children, the reproductive health field made it widely acceptable to collect fertility data from women alone.

Similarly problematic has been the assumption that husbands and wives agree simply on matters relating to fertility. This would mean that the *couple's* preferences could be represented accurately by attending to what a *woman* had to say about her childbearing plans and contraceptive use. The Western romanticised elision of husbands' and wives' desires in developed countries coincides with the domination of husbands over wives in many settings. In both cases, information on one spouse is assumed to be sufficient for analyses of fertility. As Lesthaeghe (1989) has pointed out, however, these assumptions are highly dubious, particularly where marriage and childbearing are more tenuously linked, or where spouses have more financial independence from one another (see also Mason and Taj 1987).

Financial independence is, of course, just one aspect of marital power, and just one determinant of the husband's or wife's relative position in the kinds of negotiations that are a basic part of partnership. By leaving men out of demographic analyses in any and all contexts, research assumed that husbands and wives were analogous – or even equivalent – members of the couple. The neglect of power relations of all sorts has made it difficult to make sense of reproductive decision making. The role of power relations has increasingly been recognised by demographic researchers, and this gives us another imperative to know more about both men and women.

We have been speaking of preferences, but what about the actual marital and childbearing experience of individual partners? The model described here has assumed that the partners have identical

childbearing experience. It has further assumed that either the relationship is monogamous and that all childbearing occurs within that union, or that the divergent experience of the other spouse does not matter or has no influence over the childbearing of the current partner. Yet we see that any non-monogamous marital arrangements reflect 'socio-cultural systems that ... make traditional demographic research on women's fertility alone less appropriate: polygyny [Speizer 1995], marital infidelity [Orubuloye *et al.* 1992], and marital instability [Rao and Greene 1993] illustrate these points well' (Greene and Biddlecom 2000). This 'deviance' (in the shape of polygamy and marital infidelity and instability) from the culturally specific monogamous ideal has increasingly encouraged demographers to reevaluate their categories and assumptions.

2.2 Men now receive more attention in demographic research

Interest in men's demographic roles has risen over the past few years, as witnessed by numerous review articles and analyses of what we *can't* know about fertility by studying only women (e.g., Becker 1996; see below for a summary of the reasons for this shift). Feminist thinking among researchers has played an important role in influencing the meaning of childbearing, child rearing, and marital roles in women's lives. This line of thought has advanced the study of the sexes in relation to one another and not just of women's characteristics as determinants of fertility (Presser 1997; Barnett and Stein 1998). At the policy level, feminist activism has strongly affected the formulation of health and population policy and the definition of what is important to study. Activists concerned with women's total responsibility for contraceptive use, among others, have promoted the idea that 'male responsibility' must increase.

Why research on men is now in fashion

- Women's health and rights movement – through conferences such as ICPD, Beijing, Copenhagen, Vienna
- Interest in women's status *per se* and relative to men's, not just as a determinant of fertility
- Critique of atomised treatment of women in demography and neglect of power
- Critique of intellectual limitations of demography – demographic transition theory ineffective for explaining cultural differences in reproduction
- More culturally nuanced studies of fertility behaviour reveal more than traditional approaches
- Methodological developments, including qualitative work, statistical approaches to dealing with data on couples
- Desire to understand broader context of fertility decision making – units greater than individual: couple, family, community

The inability of classic demographic transition theory (the idea that all populations eventually will pass through the same mortality and then fertility declines) to explain fertility decline in many settings has also promoted more culturally informed research on childbearing. Gender roles are at the core of the cultural roots of fertility, and thus this shift to looking at cultural *variation* rather than cross-cultural *similarity* has led to much research on gender. The concurrent rise in the use of qualitative data has also led to more nuanced examinations of gender roles in different settings, and this requires more information about and from men. The units of analysis have expanded as well, from a strict focus on individuals, to more attention to couples, families, and social (e.g., Bongaarts and Watkins 1996) and sexual (Bond 1995) networks.

Although with each passing day men are increasingly featured in studies of fertility, demography continues to care about men primarily because of their association with women, and to care about women primarily because of their reproductive capacity roles (Greene and Biddlecom 2000). More recent research has focused on women's well-being in and of itself, and not only as a determinant of fertility (e.g., Barnett and Stein 1998). It asks whether we observe the hoped-for improvements in women's status now that fertility decline has taken place, or at least begun, in so many settings.

3 Programmatic Implications of Seeing Men as Problems

Men and women relate to one another from highly differentiated social positions, reflecting culturally

constructed systems of gender. This requires an approach to reproductive health that treats social and sexual roles as part of a dynamic system of relationships, and goes beyond an approach that expands away from the clinical tendency to treat clients or patients in a social vacuum.[3] Were programmes to focus on addressing inequities in gender relations rather than on static characterisations of men's misbehaviour, they could potentially engage in a wider range of interventions.

Since men were of little interest to the family planning field for so long, and have been included in research only recently as the husbands or partners of women selected for interview, our view of their behaviour and preferences is both limited and distorted. These sketchy accounts have in turn reinforced original assumptions concerning men's minimal roles in fertility decisions and behaviour: Men are seen as *uninformed and irresponsible* with regard to fertility control; as *blocking* women's contraceptive use; as *sexually promiscuous*; and to top it off, as *underinvesting in their children* (Greene and Biddlecom 2000). There is some truth in these assumptions, but accepting them as given has supported reproductive health programmes in essentially sidelining men, rather than addressing gender relations. This next section analyses the programmatic implications of these closely related assumptions and how they can limit the capacity of programmes to address gender inequities.

3.1 Men are uninformed and irresponsible with regard to fertility control

By reinforcing women's primary responsibility for children and therefore for fertility control, and the demographic imperatives of family planning, programmes work with clients reinforces men's non-involvement. Judging men's interest in family planning to be minimal, programmes have permitted, and even at times encouraged, the disengagement of men from family planning activities. This assumption has contributed to decades of social sanctioning and programmatic support for men's non-involvement. By reflecting a sense of women's primary responsibility for children, and therefore for fertility control, and for the demographic imperatives of family planning, programmes reinforce those relations when they deal with clients. As Skibiak (1993) has shown in work on reproductive health in Bolivia, programmes marginalise men and minimise male participation by 'restricting the dissemination of information through selected gender-specific channels or by reinforcing gender stereotypes that for cultural reasons are not likely to be challenged or discussed openly' (Skibiak 1993:5), i.e., assuming male disinterest in and female responsibility for contraceptive use.

Accepting the fact of male resistance and working around it in promoting contraceptive use among women can be interpreted in two quite different ways, as the case of Bangladesh's family planning programme illustrates. One argument is that accommodation to gender-based social inequality has helped to make the programme successful but, in the long run, has weakened it (Schuler *et al.* 1995). The programme relies heavily on community-based contraceptive delivery to women in order to get around the restrictions on their mobility imposed by purdah. A critique of this approach is that it disproportionately burdens women, who have the fewest resources for dealing with the costs and risk of family planning, i.e., it does not attempt to engage men, who are seen as resistant to family planning. 'The family planning program's woman-centered approach motivates women to take responsibility for family planning. In using contraceptives, however, as in most of what they do, Bangladeshi women are extremely dependent and vulnerable' (Schuler *et al.* 1995:136). Their point is that women's subordination itself should be addressed directly, as contraception will not resolve it, whatever effects contraception may be posited to have on women's status. The response to this critique of 'accommodation' of gender constraints has been to point out that programmes have supported women in a sort of passive resistance (Biddlecom and Fapohunda 1998). Biddlecom and Fapohunda argue that community-based distribution of contraceptives to women's homes may sometimes be seen as the only way to reach women who themselves want contraception (Nazzar *et al.* 1995).

3.2 Men are barriers to women's contraceptive use

Men's assumed desire for more children, disinterest in or inability to communicate with their wives and dominance in decision making are seen as major barriers to women's contraceptive use. Together, these generalisations about men have had several contradictory consequences for family planning

programmes. Women have at times been supported in realising *their* fertility desires regardless of men's, even where this has meant covert use of contraception. All kinds of efforts to increase communication within the couple have been motivated by the idea that more communication will necessarily lead to greater contraceptive use. The idea that men are dominant in decision making has disregarded women's informal power, the power they often wield over domestic decisions. This power is often unstated and is threatened by calling attention to its existence, in settings where men must nominally make all decisions as head of the family (Krieger 1999).

Although a desire for many children has been seen as motivating men's blocking of women's contraceptive use, the real reasons may often be closely related to aspects of gender roles. Some men may want children as proof of their own masculinity (e.g., Essed-Fernandes 1993), or as proof of their wives' fertility or fidelity (Fapohunda and Rutenberg 1999). So while the strategy of family planning programmes has generally been to *work around* men's domination in household power relations, the roots of men's objections to fertility control appear to lie in gender roles and inequities, suggesting that programmes need to *address* the roots of men's objections to fertility control, which are found in gender roles and power. One area in which this has begun to occur is that of domestic violence and its impact on reproductive health (Heise *et al.* 1995). The positive relationship between number of children and domestic violence was for a long time seen as abuse resulting from large family size (see e.g., Jejeebhoy 1998). More recently, however, a study in Nicaragua found that most abuse begins at the start of a relationship, 80 per cent of it within four years (Ellsberg *et al.* 1999), suggesting that abuse *produces* high fertility, rather than high fertility leading to abuse.

Current responses by the reproductive health field to this gender-based violence, even where male attitudes are faulted, tend to emphasise an increase in women's resources but say little about changing men's behaviour (e.g., Khan 1997). A study of male attitudes in Gujarat, India, for example, found widespread sexual violence and coercion; yet offered as the sole solution, 'strong advocacy and major social changes which could empower the women' (Khan 1997:15), disappointingly avoiding suggesting what men might do. Working on preventing violence by changing social expectations and attitudes is more complicated than responding clinically and practically to the consequences of violence.

Some interesting work has been done with violent men, however. One example is Mexico's Colectivo de Hombres por Relaciones Igualitarias (CORIAC) (Liendro 1997), which brings together violent men. Men who are themselves dealing with violence, most often their own, meet voluntarily to discuss the nature of their relationships with women, the ways in which they have internalised machismo and limiting concepts of masculinity, and how to understand their own emotions better, to identify which situations risk becoming violent. 'We have to break the myth of the violent man as the exception, as pathological, because the problem is cultural. That's why we propose the concept of re-education rather than therapy' (Liendro 1997:49).

3.3 Men are sexually promiscuous

The basic acceptance of the sexual double standard that exists for women and men has led to unambitious reproductive health interventions for men. The emphasis of many programmes working with men has been on sexually transmitted disease, with far less attention paid to men's reproductive and child-rearing roles. By seeing male sexual expression as strictly biologically determined and therefore immutable, reproductive health programmes miss opportunities to work with men in ways that challenge gender stereotypes.

In Thailand, sexual encounters with commercial sex workers most often follow from episodes of public drinking (Fordham 1995). The expectation that women will be sexually inexperienced and men sexually experienced at the time of marriage,[4] the importance of potency as an element of masculinity, and high tolerance for 'excessive drinking among Thai men and for the rowdy and reckless behavior that may result' (Van Landingham *et al.* 1993:299), all contribute to the promotion of prostitution. Research from Thailand illustrates the usefulness of looking at masculinity and its links with sexual behaviour, though there is an ongoing debate as to what use to make of the information. Fordham (1995) distinguishes between the different types of social gatherings involving drinking and, just as

importantly, the different kinds of sex that Thais experience inside and outside marriage. In the public sphere, he argues, expectations about male behaviour and virility must be proven by masculine acts, efforts to impress others by womanising and spending large amounts of money.

Male sexuality has been of concern to the reproductive health field in ways that have never been true of programmes for women. For example, a programme established to address STDs in Orissa, India finds that men's sexual health concerns are focused on semen loss and virility (Collumbien *et al.* 1999). This programme and the research arising from it reflect the focus on men's sexuality, when women's fertility continues to eclipse any consideration of their sexuality.

A widely accepted emphasis on the importance of male sexual performance has led to justification of the divergent treatment of men and women in reproductive health programmes. In India, the failure to lay to rest concerns regarding male sexuality and strength (Khan *et al.* 1997) and a backlash against forced vasectomy during the 'Emergency' under Indira Gandhi's rule in the mid-1970s have helped to maintain an emphasis on female sterilisation and to entrench misconceptions about male virility and the importance of protecting it at all costs. That female sterilisation, a far more invasive surgery than vasectomy, has become the norm, while male sterilisation is viewed with suspicion, is a clarifying moment of patriarchy. In Thailand, the 100 per cent condom campaign provided condoms and penalised brothels in which they weren't being used, but did not attempt to address men's extensive use of commercial sex workers (Hanenberg *et al.* 1994). In Nepal, a non-governmental organisation likewise provided condoms as a response to the routine rape of women by landlords on whose land they were collecting fodder (Population Council 1998).

3.4 Men underinvest in their children

Traditional reproductive health programmes have closely associated 'maternal and child health' with the exclusion of men, and our field is filled with examples of the primacy we accord the mother–child relationship. But throughout the developing world in particular, we know very little about men's involvement in the lives of children (Bruce *et al.* 1995; Engle and Leonard 1995). The reproductive health field's emphasis on mothering over fathering has implied that men necessarily have little to do with the health and welfare of their children. An understanding of men as marginal to the lives of their biological children has, of course, left no room at all to learn more about their roles as stepfathers, uncles, brothers and grandfathers.

Rising levels of divorce and childbearing outside of marriage have meant that more men are living apart from their biological children than ever before, potentially providing less financial support and being less engaged in child-rearing and domestic responsibilities. These same demographic trends of divorce and non-marital childbearing mean that many men have multiple partners and biological children from more than one sexual union (e.g., in the Congo, Magnani *et al.* 1995). Studies that apply a 'deficit' model to studying fatherhood look at how much the absence of a biological father negatively affects the well-being of a child (e.g., in the United States, Garfinkel, McLanahan, and Robins 1994; in developing countries, Bruce *et al.* 1995). Since the emphasis is overwhelmingly on biological fathers, we tend to miss men's investments in other children. Men parent children other than their own biological offspring through fosterage, 'uncle'-hood, or becoming stepfathers (Bernhardt and Goldscheider 1997; Juby and Le Bourdais 1998; Townsend 1999). The health field has an important opportunity to build upon the varied and important roles men already play in the lives of their children.

4 Conclusions

Gender stereotypes continue to structure reproductive health programmes more narrowly than the vision laid out in the ICPD Programme of Action. Just as the emphasis on women's contraceptive use and reproductive health assumed *women's* exclusive responsibility for childbearing and rearing, the ways that men are introduced into existing programmes or have programmes designed for them assume understandings of men's roles and how they can fit into reproductive health care interventions. The acceptance of a static, problematic view of men is less useful than an approach that seeks to transform some of the gender inequities that inhibit reproductive health. Far from providing an objective backdrop to reproductive health programmes, research has made and reflected many of the same assumptions as the guide programmes.

No social institution or culturally determined individual preference relating to reproduction fails to prescribe or reflect different behaviours and meanings for men and women. For that reason, it is essential to understand and question the assumptions reflected in reproductive health research and programmes. Do interventions simply accept or even consolidate male power in decision making and allocation of resources, thereby potentially eroding women's power? Or do they take gender relations into account to find ways of enhancing women's status and involving men in supportive partnerships? Ill-conceived efforts to involve men in reproductive health programmes run the risk of reinforcing gender inequities, conveying a sense of simple symmetry in men's right to reproductive health services, increasing violence against women, or entrenching managerial hierarchies in health programmes by hiring men to positions above women because of their greater mobility. An additional risk is that male involvement programmes continue to be evaluated on the basis of increases in contraceptive prevalence, rather than any gender-related outcomes.

Few good models for male involvement work exist, and little research has measured the broader impact and benefits of male involvement in family planning and reproductive health. The work that has been done, however, suggests several guidelines for further work on male involvement (see Greene 1998).

4.1. Clarify the objective of involving men

Any programme wanting to involve men needs to articulate its reasons for doing so. Aside from a desire to repeat the Cairo rhetoric, what are its motivations for wanting to bring men in? The reasons for involving men and approaches to doing so are closely intertwined and should be carefully articulated. The most common approach seems to be the recruitment of men to facilitate women's contraceptive use. This follows naturally from the conclusion drawn by earlier studies that portrayed men as 'obstacles' to women's contraceptive use. The second most commonly pursued goal is to provide reproductive health services for men, much as they have been provided for women. While this in itself is not objectionable, less acceptable are the assumptions that (1) there is complete symmetry between the sexes that calls for services for men completely on the basis of 'fairness'; and (2) clinical approaches to men's sexually transmitted diseases and contraceptive needs will address gender inequities in reproductive health. Few programmes have taken the plunge to initiate work that erodes the gender inequities inhibiting reproductive health.

4.2 Anticipate the impact of programmes on gender relations

A greater sense of 'doing no harm' is needed in programme development, and it must extend to the social implications of reproductive health programmes. By reflecting assumptions about sex roles – e.g., men's detachment from child-rearing, the demands of their sexuality; women's primary responsibility for children and therefore for fertility control – and about the demographic imperatives of family planning, they reinforce those relations when they deal with clients. The impact of any intervention on gender relations needs to be anticipated and addressed.

4.3 Conduct research but don't hide behind it

The parting refrain of papers on male involvement is often the recommendation that 'more research on men is needed in order for interventions to be developed.' Traditional demographic data are not necessarily more useful given the new directions in which male involvement must go; they are laden with assumptions, and often work to involve men in activities whose basic premises have not been questioned from a gender equity perspective. Thus the implication is not that we need to rush out and interview as many men as possible before we can develop any policy or programme initiatives on male involvement. There is much existing research by anthropologists and other social scientists that would shed light on gender relations and inequities in specific settings and how these affect reproductive health. Closer linkages between work on male involvement and women's empowerment will develop our knowledge of gender inequities and how they affect reproductive health.

4.4 Multi-sectoral social change

Many male involvement programmes tacitly emphasise the position of family planning at the heart of population policy, rather than as one of a series of wider health care objectives. For too long,

the population field has placed the exclusive and complete burden of population stabilisation on family planning and reproductive health programmes. Population policy is important, and for that reason, the provision of family planning certainly is as well. But the focus on the demographic efficacy of family planning and of the efficacy of involving men in reproductive health significantly constricts the impact of these programmes. The treatment of male involvement as a separate activity directly reflects the ways in which the social themes we see in our particular area of work, i.e., reproductive health, are treated in a vacuum with few conceptual or practical links being made to other areas. Responsibility for the social change implied by tinkering with gender relations must be shared with other institutions and programmes, and other areas of intervention must be brought into cooperation with this objective. For too long, the population field has placed the exclusive and complete burden of population stabilisation on family planning and reproductive health programmes. Other areas of intervention must be brought into cooperation with this objective. This lingering emphasis on family planning and contraceptive use is in considerable tension with the much further-reaching reproductive health and gender equity orientation many programmes now officially endorse.

Notes

1 One additional recent source of attention to male involvement has come from men's advocates, who argue that men have long been excluded from an important area of health care services and, in all fairness, also deserve some of the basic services that comprise reproductive health care.
2 This section builds on a framework presented in an extensive review by Greene and Biddlecom (2000).
3 By relying upon analytic categories and singular identities, modern science tends to neglect the contextual connections affecting every person, institution, or social action (Dumont 1981).
4 Expectations of men in the sexual arena make it more difficult for them to admit their own ignorance about reproduction and sexuality (Rogow 1990: 2).

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