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Positive masculinity programmes and sexual and reproductive health behaviours among boys and men in poor urban settlements in Democratic Republic of Congo, Nigeria, and Rwanda

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Abstract

As Positive Masculinity (PM) Programmes continue to develop globally, it is important to examine their role in Sexual and Reproductive Health and Rights (SRHR) outcomes. This multi-country qualitative study was conducted using in-depth interviews (IDI) and focus group discussions (FGDs) with community members, beneficiaries and implementers of PM programmes. The findings show that PM programmes are designed using a gender lens to make boys and men more aware and conscious of harmful masculinity traits and their effect on SRHR. The beneficiaries of the interventions report imbibing positive SRHR behaviours by being sexually responsible – upholding sexual rights, taking precautions against sexually transmitted Infections (STIs) and learning proper communication with their partners. They also report acting as vanguards of positive gender norms to their families and peers. Although there are challenges in implementing PM programmes, the results of the study suggest that interventions targeting boys and men hold promise for improving boys' and men's health behaviours and promoting gender equality in poor urban settings. *(Afr J Reprod Health 2024; 28 [8s]: 32-40).*

Keywords: Positive Masculinity; Sexual and Reproductive Health and Rights; Boys and Men; Poor Urban Settlements

Résumé

Alors que les programmes de masculinité positive (PM) continuent de se développer à l'échelle mondiale, il est important d'examiner leur rôle dans les résultats en matière de santé et de droits sexuels et reproductifs (SDSR). Cette étude qualitative multi-pays a été menée à l'aide d'entretiens approfondis (IDI) et de discussions de groupe (FGD) avec des membres de la communauté, des bénéficiaires et des responsables de la mise en œuvre des programmes PM. Les résultats montrent que les programmes PM sont conçus en utilisant une optique de genre pour rendre les garçons et les hommes plus conscients des traits de masculinité néfastes et de leurs effets sur la SDSR. Les bénéficiaires des interventions déclarent avoir adopté des comportements positifs en matière de SDSR en étant sexuellement responsables – en respectant leurs droits sexuels, en prenant des précautions contre les infections sexuellement transmissibles (IST) et en apprenant une bonne communication avec leurs partenaires. Ils déclarent également agir en tant qu'avant-gardes des normes de genre positives auprès de leurs familles et de leurs pairs. Bien que la mise en œuvre des programmes PM présente des difficultés, les résultats de l'étude suggèrent que les interventions ciblant les garçons et les hommes sont prometteuses pour améliorer les comportements de santé des garçons et des hommes et promouvoir l'égalité des sexes dans les milieux urbains pauvres. *(Afr J Reprod Health 2024; 28 [8s]: 32-40).*

Mots-clés: Masculinité positive ; Santé et droits sexuels et reproductifs ; Garçons et hommes ; Pauvres établissements urbains

Introduction

Engaging men and boys in Positive Masculinity (PM) interventions have proliferated rapidly as a strategy for improving Sexual and Reproductive Health and Right (SRHR) outcomes in sub-Saharan Africa(SSA)[1,2]. Male-targeted initiatives are meant to help men confront patriarchal norms that increase gender inequality impeding SRHR outcomes[3]. While there are evidences of these programmes, little is known about their effectiveness, including the approaches used in supporting boys and men to unlearn harmful masculinities[4,5]. Therefore, gaps exist as to what

works and how they work; and the extent PM interventions address harmful masculinities in the context of SRHR[6].

Sub-Saharan Africa has the highest number of poor urban settlements, with about 62% of the region's population residing in slums[7]. Poor urban settlements are characterized by lack of basic services, overcrowding, substandard housing, and social exclusion. Spatial and material conditions like poverty in poor urban settlements intersect with gender relations to shape SRHR outcomes[8]. Thus, poor informal settlements are affected by high risks of poor SRHR outcomes, including Sexual and Gender-Based Violence (SGBV), HIV/AIDS, unintended pregnancies, and unsafe abortion[9,10].

The importance of gender equality in improving SRHR outcomes has been an enduring issue even before the 1994 International Conference on Population and Development (ICPD) in Cairo[6]. However, the Cairo conference signalled a shift from population control to a human rights-based approach where everyone has the power to make decisions regarding their SRHR without undue influence[5]. The Cairo Programme of Action also emphasized that efforts must be put in place to engage men to promote gender equality.

To understand the importance of engaging boys and men, we must reflect on the African traditional masculine norms or the cultural expectations of men regarding their roles and relationships. From early adolescence, boys are socialised to be brave, take risks, and not be irrational or emotional when overwhelmed with events[11,12]. Likewise, men are expected to be hard, provide for their family, and be self-reliant[13]. This gender norm affects how men regard their health and how they behave towards others. For one, it hurts women and children, and it supports men's dominance over women, including preventing them from making decisions about their SRH[5].

As for men, it puts them at risk because it encourages them to engage in risky sexual behaviours while preventing them from taking the recommended tests for diagnosing sexually transmitted infections (STIs) or openly talk to a health provider[14,15]. Furthermore, men underuse medical facilities for the treatment of diseases and this is linked to their identities and roles as men[16]. Thus, men's risk-taking behaviour and their underutilisation of healthcare services are strongly linked to gender differences and predominant norms of masculinity.

Positive Masculinity interventions have a critical role of challenging gender norms affecting SRHR outcomes. Positive masculinity is defined as the adoption of pro-social behaviours, attitudes, and beliefs by boys and men, leading to observable positive outcomes for themselves and others[17]. The concept was captured in the Positive Psychology/Positive Masculinity (PPPM) framework to draw attention to male strengths, and the positive aspects of being male[18]. It is believed that PM can be taught to boys and men through a socialisation process, leading to a change in the perceptions of masculinity.

It is acknowledged that PM interventions are growing globally, but it is also important to learn from the approaches and contributions used to improve SRHR outcomes[8,19]. Continuous examinations of emerging engagement strategies will help inform the refinement and efficacy of future positive masculinity programmes. However, there is limited evidence on strategies used to implement PM programmes in poor urban settings and how they are linked to improved SRH behaviours. To that effect, there have been calls for more documentation of the experiences of the beneficiaries of PM programmes[20].

Therefore, the aim of this study is to address the above gap by examining the strategies used to implement PM programmes in poor urban settlements. The study will also examine how PM interventions affects SRH behaviours of boys and men. The study responds to a strong felt-need in the Africa Union Agenda 2063 and the Sustainable Development Goals (SDGs) which thrives for an improved SRHR outcomes and SGBV – free societies.

Methods

Study design and sites

The study was qualitative research that was designed to elicit the experiences of participants of PM programmes in poor urban settlements. The study was conducted in purposively selected slums located in Enugu, Nigeria; Kigali, Rwanda; and Kinshasa, Democratic Republic of the Congo (DRC). In these countries, patriarchy, male-privilege norms, and poverty play significant roles

in gender disparity and adverse SRHR outcomes[9,21–23]. The study involved triangulation across different datasets to offer multiple and insightful perspectives.

Study participants

The study participants include residents in informal settlements who benefitted from male-targeted PM programmes, implementers of the programmes, community leaders and relations of beneficiaries. In-depth interviews (IDI) and focus group discussions (FGDs) were held with boys (aged 18-24 years) and men (aged 25-50 years). Additionally, IDIs and FGDs were held with women and girls and married women aged 18 and above who reside in informal settlements and are aware of positive masculinity programs implemented in their community. Furthermore, key informant interviews (KIIs) were conducted with community members, including key stakeholders and leaders in target informal settlements who were aware of PM programmes. Lastly, those who worked as implementers of positive masculinity programmes in the target areas were included as participants in the IDIs.

Instrument and data collection

The instruments were developed by the researchers drawing from literature on gender norms, SRHR, masculinity, and masculinity programmes in SSA[17,24]. The breakdown of the interviews conducted gathered across the three countries were as follows: 30 IDIs with men and boys (10 per country), 12 FGDs with men and boys (4 per country), 30 KIIs with community leaders and stakeholders (10 per country), 21 IDIs with women and girls (7 per country), 6 FGDs with women and girls (2 per country) and 12 IDIs implementers (4 per country). Overall, 63 IDIs, 18 FGDs and 30 KIIs were conducted. The community leaders, girls and women were interviewed to confirm behavioural changes resulting from the programmes. The programme implementers were interviewed to unpack the programmes' strategies, objectives and outcomes. Table 1 captures the sociodemographic characteristics of the participants. The participants were reached through purposive, judgement and snowball sampling technique.

Table 1: Sociodemographic characteristics of study participants

Descriptions	Nigeria	DRC	Rwanda
Data sets			
IDI	21	21	21
KII	10	10	10
FGD	6	6	6
Gender			
FGD (total of participants in the sessions)			
Male	4(28)	4(30)	4(31)
Female	2(12)	2(17)	2(13)
IDI&KII			
Male	20	19	15
Female	11	12	16
Age			
FGD (total of participants in the sessions)			
18-24	3(18)	3(15)	3(21)
25-above	3(22)	3(32)	3(23)
IDI&KII			
18-24	11	9	13
25-above	20	23	18
Marital status (Including FGD participants)			
Single	20	31	23
Married	49	44	51
Divorced/Separated	2	4	1
Educational level (Including FGD participants)			
Completed any formal education	64	68	72
Did not complete formal education	7	11	3

The implementers of positive masculinity programmes and community mobilisers played crucial roles in helping to mobilise those who actively participated in PM programmes. Women and girls were reached through snowball techniques through the assistance of boys and men who were interviewed. The participants were informed of the study objectives and asked to participate. Those who accepted were scheduled for interview at the time and venue of their choice. Most of the interviews were conducted within the community and offices of the implementers.

Data analysis

Data analysis followed both inductive and deductive approach, with preconceived themes that border on gender, SRHR and key learnings from PM programmes. To achieve this, the data were loaded into NVivo software for qualitative analysis. The researchers read through selected transcripts, created broad topical categories of interest that address the research questions, and sorted the data into these categories. This was reached through multiple reflections on data to generate codes. The codes went through several rounds of sorting, organising and renaming to develop into emerging themes. The presentation followed the use of quotes to illustrate findings in each theme.

Ethical consideration

The study received ethical approval from the ICRW's Office of Human Research Protection, Rwanda's National Ethics Commission, Nigeria's National Institutional Review Board, the University of Kinshasa Research Ethics Committee, and the University of Nigeria Research Ethics Board. The project was guided by the Tri-Council Policy Statement on Research Ethics and related principles. Participants and organizations involved in this study were given unique study identifiers and their identities were anonymized in the study data.

Results

Strategies of positive masculinity programmes

Using gendered lens

When engaging boys and men, PM implementers reported that they employ gendered lens by making gender more visible in their programmes which are commonly centred on community mobilisation and education. They make beneficiaries understand that standards and opportunities differ systematically for men and women regarding SRHR. This implies that compared to women, men tend to have a satisfying and safe sex life as well as the freedom to decide when, how, and if they engage in sex. They linked this to power and unequal distribution of resources. To correct this norm, implementers highlighted gender imbalances and bias in everyday relationships to the beneficiaries. They asserted that inequality and imbalances are created by society, into which people are born, and that they are responsible for changing them. As illustrated, they thrive to change the perspectives of the beneficiaries:

"The teachings that we deliver are teachings focusing on changing that man's perspectives. He is born male and the Rwandan society will also shape him into a man, she is born a girl and the society will shape her into a woman. The way our society shaped us, there is inequality between males and females but when you change their perspective and they see that they are equal." (IDI: Rwanda, Man, Implementer).

Implementers described their roles as multifaceted; levering different techniques to reach men in poor urban settlements. Their interventions involved face-to-face contact with men and boys in a hall and other times, engaging couples separately or in groups. In Rwanda, a programme implementer reported that they often visit families to resolve sexual and reproductive health issues like sexual withholding and forced sex. To this end, couples appear eager to listen and are usually ready to make the needed change. For example:

"They (referring to married women) would be saying, 'we are hungry because of you, you come home drunk.' So, we go there, we talk to them, we tell them what to do and the husband starts to change his behaviour. When the wife sees that his husband is changing, she begins to understand her husband's weaknesses and agrees to sleep (have sexual intercourse) with him again." (IDI: Rwanda, woman, Implementer).

"When you talk about sexual intercourse between couples, you see that they start to listen carefully and that's where they understand that they were behaving badly: jumping on someone who is sweeping, cleaning…" (IDI: Rwanda, woman, implementer).

Implementers also utilised safe-space strategy which allows them to engage men and boys separate from the opposite sex. Within this space, they organise the seating positions to be as circular as possible and encourage participants to speak

freely. Then they raise controversial issues and watch them debate while the implementers act as facilitators, asking them to reconsider contested issues carefully. This strategy appears to work on highly contested issues like sexual rights. For illustration:

"The hardened patriarchal adherents amongst them, we give them food for thought. There's one we trained, we asked him; how do you let your girlfriend know you want to sleep with her and he said - I do not need to tell her, I just go ahead and sleep with her. We said, but that means you are raping her. He said no, that the girl is his girlfriend and he does give her money. We train these young ones and they confessed that their relationship improved, this emanates from talking responsibly and behaving the same." (IDI: Nigeria, Woman, Implementer).

"There is also a platform for all men where they meet and discuss what is not going on well, what is good or need to be improved and they also transform other men so that they become admirable men. There are also "being activists" to prevent GBV into their cells and transmit messages during cell meetings." (IDI: Rwanda, Women, Implementer).

Implementers also strive to raise awareness among men and boys about the negative aspects of certain masculine norms, such as risk-taking, a sense of entitlement, and the exertion of dominance over women, all of which have adverse effects on their SRH. Moreover, they made the participants see that improving their sexual and reproductive health is linked to improving that of their wives, children, and extended family members. This could start by bridging the imbalances in social relationships between them and their partners and by contributing in small ways to family activities. Furthermore, they advised beneficiaries to not abuse alcohol, avoid unsafe and unplanned sex and the benefits of family planning. One implementer recounted how they asked men to be intentional about communicating their sexual desire with their partners:

"For example, when you want to make love, you have to do foreplay, you can't jump on someone without preparation first. If you talk to her badly, you are drunk and you come and call her: "You come here" it can't work! just like she can't ask you for it when you are not ready, are you going to accept? So, we told them to do foreplay before sex, and then we talk about having children you are able to take care of, not because your neighbour has many. You have to think about their school fees, their health insurance, and clothes. Look at where you are going to find means for all these and the energy it will cost you instead of having a lot of children as if it is a project." (IDI: Rwanda, Man, Implementer).

Meeting health and economic needs

Implementers also do well to meet the health and economic needs of the community members in the intervention sites. On meeting health needs, they distribute over-the-counter drugs and contraceptives and encourage men and boys to use them to protect themselves from sexually transmitted diseases. In Nigeria, implementers report distributing them at strategic locations, including participants' homes. For illustration:

"We were using our vehicles to go drop commodities and drugs at strategic locations. So, we dropped our Condoms at strategic locations and then our community facilitators distributed them home to home using their protective PDAs. And at the end of the day, we collated our Data. We noticed that there was an increase in the number of condoms we distributed during the lockdown as to what we distributed before." (IDI: Nigeria, man, implementers).

Some implementers infuse skill acquisition in PM interventions to meet the economic needs of participants. This was considered a necessary step to help unemployed men and boys acquire the needed skills to help them become engaged in productive activities. Indirectly, this contributed to their increased turn out and participation in PM programmes. But it also helped men with alternatives to earning a living:

"I am not a shoemaker yet, but if I buy materials now, I can make shoes, because we jotted things down. The program really instilled and inculcated practical business skills into participants." (IDI: Nigeria, man, participant).

Effects of PM programmes on SRHR behaviours

Findings show that PM programmes are changing traditional masculinity traits in men. Men and boys who participated reported altering their initial stance on women as being 'lesser' to men, including recognising women's sexual rights. Participants also admit being able to differentiate between sex and gender. Those who held the view that women are to blame for sexual and reproductive health challenges also reported changing this notion as captured in this quote:

"Concerning the training on sexual reproduction, the causal agent is usually the woman, but here we saw that responsibility are shared among both parties: and that each one must understand in what he is performing well and in what he is not to, then try to share the responsibility and seek a solution." (IDI: Congo, Man, Participant).

The participants reported that the programme changed their understanding of rape. Those who had earlier thought that they have a right to their partner's body, especially if they are providing their needs report having a rethink. The interventions tasked men to be aware of the consequences of engaging in rape and to rather communicate with their partner for consent. The following are illustrative quotes:

"I have now known that having sexual intercourse by forcing the partner is not a good thing. If you have the desire to have sex with your partner, you must caress her to give her the same desire as you so that things go smoothly." (IDI: Congo, Man, Participant).

"They made us understand the importance of consent. They let us know that 'NO' from a lady is 'NO' when it comes to sexual relationships. So, we learnt that men should not coerce females to have sex with them, else it translates to rape." (FGD: Nigeria, Boys, Participants).

The participants also report being more aware of their health and safety. They are more responsible and are making genuine efforts to keep themselves and their partners safe. They report being conscious enough to abstain from indiscriminate sex and from having sex without protection. Those who have never used protection also reported changing that aspect of their lives. Those who were already infected reported seeking medical attention while abstaining from sexual intercourse:

"Well, like the use of condoms; I didn't use that before. But for now, I protect myself with it during sex intercourse." (IDI: Congo, Boy Participant).

"When one has an infection, he shouldn't spread it to his family and everyone else. He should treat it first. When one is sure one is 100 percent cured, one can then meet one's wife. Once you are infected, you will know because there are signs. Once you are infected, you should go for a test and then medication." (FGD: Nigeria, Men, Participants).

Data show that beneficiaries acted as vanguards of PM learnings to their friends and siblings. Some reported correcting those who mistreat their partners and girls in general while some report cutting off those who refuse to change. It is also important to note that some of the participants went the length of incorporating gender activities in their work settings:

"One of the benefactors of this program now has a gender-based program in her school, where they give awards to the most gender-sensitive student. It is such that children are encouraged to play with toys of their choice, unlike in the time past when a boy will be discouraged from playing with a doll instead of a toy car." (IDI: Nigeria, Woman, Implementer).

Challenges of PM programmes

Engaging men and boys to change harmful attitudes and practices regarding SRHR is not without problems. Implementers recount facing criticism from those who fear that their teachings would effeminate men and create rebellious women who would no longer be submissive to male authority. Sometimes, this criticism is based on religious teachings, such as the belief that the Bible instructs women to be submissive to their husbands. This was the experience at the early stages of the intervention as described by one of the implementers in Nigeria:

"*When I started this program, approaching men was a problem, because they tend to perceive those*

who abide by the teachings as women wrapper (a man controlled by his wife). They called the concept an alien concept." (IDI: Nigeria, Woman, Implementer).

Furthermore, implementers reported encountering funding challenges. The data reveals that certain PM programs are self-funded, while others receive financial support from governments and donor agencies, though the support is often insufficient. As such, the interventions appear to be on a one-off basis and not long-lasting as they would prefer. Additionally, they often face the challenge of completing their modules due to scheduling conflicts of the beneficiaries who also bear the responsibility of providing for their family. For example:

"There are 17 modules usually, we had to teach one module per month due to participants' availability which was affecting their attendance, some were absent because they had to be at their daily work for gaining money and they prefer to be at work rather to attend Rwamrec meetings." (IDI: Rwanda, Man, Implementer).

Discussion

The study examined the strategies used by PM implementers and the experience of beneficiaries of PM interventions on SRHR in Congo, Rwanda and Nigeria. The findings show that PM programme implementers use multiple strategies to engage boys and men and that beneficiaries are improving their sexual and reproductive health behaviours. This has been reported elsewhere[20,25–27]. In studies conducted in SSA, it is reported that programmes engaging men resulted in improved knowledge of HIV/AIDs and reduced risky behaviours such as having multiple sexual partners and having unprotected sex[28,29]. Thus, PM programmes holds great potential for improved reproductive health outcomes for men and boys and the community at large.

In this study, PM implementers were focussed on helping young men become gender aware, participate in curtailing all forms of sexual and gender-based violence, instil healthy masculinity, and correct gender myths in a patriarchal social system. The beneficiaries of PM programmes report positive gender attitudes and practices and were reconditioned to promote these outcomes in their communities. Other studies have shown that PM programmes targeting males reduces harmful masculinity traits as well[2,3,5,19].

Across the countries studied, PM implementers utilised four programming characteristics designed using gender lens. First, they utilised multicomponent activities that involved education, debate and persuasion of participants. Second, they utilised multilevel programming by mobilising community members. Third, they worked with men and women separately, and interacted with couples. Finally, the implementers appeared to be well experienced with planned modules for learning. These characteristics were identified as effective gender-transformative approaches capable of successful behavioural change[5].

Also important were the strategies of giving back to the communities in the form of supplying free health commodities and providing skill acquisition programmes. While this served the importance of getting them engaged in the programme, beneficiaries ended up acquiring the resources they need to make positive change. In a study in South Asia, rural boys and men were attracted through popular films[19]. Moreover, the aspect of skill acquisition is based on the understanding that financial freedom and economic independence is an important requirement to attain manhood in Africa[20]. Employment boosts men's identity and self-esteem, and may also reduce sexual crimes like rape. In the current study, free health commodities and skill acquisition programmes motivated beneficiaries to change their attitudes and encouraged them to act as vanguards of PM by encouraging their friends to also make positive changes.

All these initiatives promoted positive gender and health-related attitudes and practices in young men and boys. It further lends credence to the call for multiple initiatives when engaging boys and men in SSA[26]. The multiple initiatives used resulted in beneficiaries being more aware of their SRH needs and firmed up their sense of personal responsibility for their actions and self-reliance. Many reported altering their initial stand about what constitutes sexual rights and communications with partners. This led to the reduction of rape and indiscriminate sex, especially unprotected sex. They also reported learning how to take responsibility for their health by treating infection

and refusing to engage in sexual intercourse until after treatment.

The study is limited on the basis that it did not quantify the level of SRHR outcome recorded by the PM programmes. Nevertheless, the findings of this study show that PM programmes have great potentials for improving SRHR outcomes in poor urban settlements as well as contributing significantly to promoting gender equality. The strategy of meeting the needs of men is central to the success of the programmes. But there is more to be done to deepen the activities of implementers even as they navigate the resistance caused by the economic and cultural milieu of men. Although the implementation of gender-transformative programmes are hardly uniform[30], the importance of resources, communities and relationships remain central.

Conclusions and recommendations

Boys and men are confident in their sense of self when provided with the help they need. This help could be in the form of programmes that promote positive gender and health attitudes and practices that help meet their SRHR needs. Therefore, PM programme managers and implementers need all the support to improve their engagements as well as evaluate the outcomes of their work in poor urban settlements. Future PM programmes must also tap into young men's socio-economic and cultural milieus when engaging with them. PM programmes will not only lead to improved gender relations but will ultimately improve health for all.

Contributions of authors

AO, JE, CA, CU, and CI, Conceptualised and designed the study; AO, IB, FR, KO, CN, and CA collected the data; AO, CU, IEO and CI prepared the manuscript. All authors read and approved the manuscript.

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