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Men's Engagement in Reproductive Health and Prevention of Gender-Based Violence

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Abstract
The purpose of the present study was to address the question of whether there are differences between rural and urban men in: (a) reproductive health knowledge, attitudes and behaviors; (b) trauma, prevalence and prevention of violence; and (c) construction of masculinity. The study was conducted in eight villages, four villages representing rural areas and four villages representing urban areas. Sixty samples were taken from each village/*kelurahan* leading to a total of 480 samples. The entire samples were adult married men aged 25−35 years. Data were collected using questionnaires. Results indicated that there were significant differences between rural and urban areas with regard to reproductive health-related knowledge, attitudes and behaviors, men's roles in reproductive health and domestic chores, and violence and prevention of violence. Meanwhile, there was no significant difference in childhood trauma and masculinity between rural and urban areas.
Keywords: Men Engagement, Reproductive Health, Gender-Based Violence

1. Background

Currently, reproductive health priorities in Indonesia include four components: (1) maternal and newborn health; (2) family planning; (3) adolescent reproductive health; and (4) STI and HIV-AIDS. Those priorities relate to the current trend of an increased intensity of reproductive health issues related to adolescent life such as the increasing prevalence of sexually transmitted diseases (STIs). Since the rise of the HIV epidemic, sexually transmitted diseases increasingly spread to almost all areas previously relatively "free" from the diseases.

In every stage of the human life cycle, there is a risk of violence adversely affecting reproductive health; even, it frequently can result in death (Watts & Zimmerman, 2002). Thus, violence constitutes an important factor affecting one's reproductive health. According to Middleberg (2004), in addition to this factor, gender represents a dominant factor in reproductive health. It relates to the complexity of family decision making in reproductive health originating from the difference in male and female roles. Other factors have been taken into account by various researchers, such as knowledge of reproductive health (Biney, 2011), romanticism and gender identity (Ugoji, 2011), self-concept (Ugoji, 2013), education and age of marriage (Alam, 2012), age of marriage and income (Kuunibe *et al*., 2012), the level of awareness and wellness (Jumar *et al*., 2012), cultural sensitivity and taboos (Roudi-Fahimi & Ashford, 2008).

The complexity of factors affecting reproductive health requires a comprehensive approach to addressing these issues. A number of studies have shown that the approaches used have been quite varied. According to Armstrong (2003), health institutions and community-based agencies require coordination of resources, strengthening of networks and strategies for linking sexual and reproductive health issues to the service systems. Other approaches used included implementation of human rights (Shaw and Cook, 2012), the mechanism of problem prioritization (Mayhew and Adjei, 2004), the development of school libraries (Anasi and Nwalo, 2012), an increase in the knowledge of risk factors for reproductive health (Gazmararian *et al*., 2000), an increase in the accessibility and quality of reproductive health services, especially for pregnant women (Cham *et al*., 2005), family planning services (Kassa *et al*., 2010), and the priority for the integration of reproductive and sexual health services (Berer, 2003).

Gender discrimination in communities has adverse consequences for both men and women; however, women suffer more. Gender has effects on reproductive health through various ways: access to assets, reproductive health-related decision making, values related to women's health and life, expectations of reproductive health, violence and threats of violence (Middleberg, 2004). Despite the rare recognition, the

adverse effects of violence are actually experienced by the perpetrator itself. These effects also include various non-physical aspects such as psychological, reproductive health and economic aspects. These effects are intangible and persist in the long term.

Psychological suffering, as one of the effects, is often increased by a number of things. Studies by Bostock *et al*. (2009) and Bell (1985) showed that the victims of violence suffer long due to very limited options to obtaining support and protection. The study by deMaris and Kaukinen (2008) showed that victims of violence often had post-traumatic stress disorder precisely when their partners were arrested by police. Other effects suffered by the victims relate to: health (Thomas *et al*., 2008), maternal-child life (Huth-Bocks *et al*., 2004), pregnancy (Jasinski, 2004), marriage/cohabitation (Cherlin *et al*., 2004), personal and social interactions (Daro *et al*., 2004) and divorce (Stolzenberg and D'Alessio, 2007). In the macro scale, a study conducted Waters *et al*. (2004) even showed violence occurring in every country had a significant effect on the Gross Domestic Product (GDP).

Despite the far-reaching effects, the response of women as the victims of violence often tends to be passive, apathetic and submissive. These attitudes are influenced by their environment that tends to blame the victims. Female victims of violence often face dilemmas and more complicated problems when they "expose" their case to the public. The study by Miller (2003) found that the arrest of the perpetrator by the police allow repetition of domestic violence. Submissiveness of the female victims of violence has been found by several researchers. The study by Itela (2009), for example, found that women tend to blame themselves when they are subjected to violence. Meanwhile, Draucker, *et al*. (2000) identified women's responses to domestic violence against them: telling others, rationalizing violence and seeking a safer life. According Bernett (2000), patriarchal culture, women's economic dependence and the practice of unfair justice system are all the factors that encourage women's submissiveness.

Programs to increase men's engagement in both reproductive health and prevention of violence are carried out in the framework of gender equality in communities. Malcher (2009) suggests that it is important for social justice. A variety of studies has indicated several factors affecting men's engagement in gender equality programs. The study by Casey and Smith (2010) suggested such factors as personal experience or exposure to past violence, support of the group or role models who have joined the initiative earlier, and relationships with or attention to the female role models in the group. Smith's case study (2006) of teenagers in the UK showed that the way men positioned themselves in the discourse of masculinity had important implications not only for the masculine identity, but also for the health-related behaviors.

Another study by Nkuoh *et al*. (2010) indicated that men's participation in women's reproductive health (maternal postpartum checkup and voluntary testing of HIV-AIDS) is influenced by socio-cultural obstacles centered on traditional beliefs and gender roles. Those obstacles are the beliefs that pregnancy is "women's business", that men's main role is the breadwinner and also that there is a perception of jealous men for those men accompanying their wives' checkups. Meanwhile, Morrell and Jewkes (2011) found differences in motivation among men involved in childcare.

Patriarchal culture with all of its derivatives is thus influenced by many things including the socio-cultural environment. According to the study by WHO (2010), factors such as class, caste, ethnicity, sexuality, religion, literacy and age create a manhood expression, leading to differences in power and men's marginalization. The study by Crosby *et al*. (1998) demonstrated the unique differences between rural and national samples in relation to unsafe sexual behaviors and health in general. Meanwhile, Courtenay (2000) identified the differences between rural and urban masculinity.

The purpose of the present was to address the questions of: a) whether there are differences in reproductive health knowledge, attitudes and behaviors between rural and urban men: 2) whether there are differences in trauma, prevalence and prevention of violence between rural and urban men: 3) whether there are differences in the construction of masculinity between rural and urban men.

2. Methods

The present study was conducted in eight villages which consists of four villages representing rural areas and four villages representing urban areas. The study was conducted in eight villages, four villages representing rural areas and four villages representing urban areas. Sixty samples were taken from each village/*kelurahan* leading to a total of 480 samples. The entire samples were adult married men aged 25–35 years. Four villages in the West Lampung Regency represented the rural areas and four villages in Bandar Lampung City represented the urban areas. The instrument used in the study referred to the IMAGES (International Men and Gender Equality Survey) with some modifications. It consists of four main components in addition to respondents' socio-demographic data. Those components include: a) men's knowledge of, attitudes toward, and roles in family reproductive health; b) past trauma; c) violence; and d) prevention of violence. Men's knowledge of reproductive health was measured from their knowledge of HIV and AIDS (10 items). Men's attitudes toward and role in family reproductive health were also measured using 10 items. Past trauma was measured using 7 items, violence 7 items, prevention of violence 10 items and masculinity 11 items. Data were collected after the selection of the participants. Data analysis was performed using *t*-tests.

3. Results

Table 1 – Respondents' socio-demographic characteristics

No.	Characteristics	Category	Rural (%) N=240	Urban (%) N=240
1	Average age		21.0	30.0
2	Education	No schooling (%)	0.9	0.4
		Elementary school graduate (%)	23.1	23.1
		Junior high school graduate (%)	22.7	22.7
		Senior high school graduate (%)	44.0	44.0
		Associate degree (%)	3.6	3.6
		Bachelor's degree (%)	6.2	6.2
3	Religion	Islam (%)	98.7	99.5
		Christian (%)	0.4	0.5
		Other (%)	0.9	0
4	Ethnicity	Javanese (%)	59.1	54.2
		Lampung (%)	12.1	19.6
		Sundanese (%)	17.5	8.7
		Other (%)	11.3	17.5
5	Income (IDR)	< 1 million/month (%)	91.6	54.4
		1–5 million/month (%)	7.1	44.7
		5–10 million/month (%)	0	0.9
		>10 million/month (%)	0	0
		N.A (%)	1.3	0

Source: Analysis of Primary Data, 2014

3.1. Men's Knowledge of, Attitudes toward and Role in Family Reproductive Health

In general, respondents' knowledge of reproductive health remained relatively low. Their knowledge of reproductive health was more a myth than the correct knowledge of reproductive health. For example, approximately 6% of respondents believed that a person has been exposed to HIV/AIDS due curse, witchcraft, etc. Most respondents did not have adequate knowledge of either the causes, diagnostic methods, spread/transmission and treatment of HIV and AIDS, although they claimed to have heard about it. Ninety percent and 89% of urban and rural respondents, respectively, have heard the term HIV and AIDS, but did not recognize the features of the disease. For example, they did not have knowledge about the causes, modes of transmission, prevention methods, and methods of identification (blood tests). Only 16% and 21% of rural and urban respondents, respectively, recognized the true cause of the disease. Furthermore, 39% and 44% of rural and urban respondents, respectively, had the correct knowledge about

the mode of transmission of the diseases. Sixteen percent and 18% of rural and urban respondents, respectively, had correct knowledge about the prevention of the disease. Forty eight percent and 49% of rural and urban respondents, respectively, had knowledge of the methods of identification of the disease. Most respondents (77% and 84% of rural and urban respondents, respectively) have never heard about VCT. Means and standard deviation of the respondents' total correct responses about HIV and AIDS (on eight items) was 5.7 ± 1.2. The average total score of urban respondents was higher (5.9 ± 1.3) than that of rural respondents (5.6 ± 1.2) ($p < 0.001$). Thus, statistically, there was a difference in knowledge of HIV and AIDS between urban and rural men.

Lack of knowledge of reproductive health was also associated with reproductive health attitudes and behaviors, which were less supportive or even unsafe. Low condom use implicitly reflected a strong patriarchal culture, as shown by the presumption that the spacing of pregnancy was women's domain. Men had the full right and authority to the number of children desired. It also reflected a lack of knowledge of condom use for the prevention of sexually transmitted diseases, especially when men had unsafe sex. A total of 80.9% and 63% of rural and urban respondents, respectively, had never used condoms. Based on the indicator of having sexual intercourse with one partner in a year, rural men had relatively safer sexual behaviors (94.9% versus only 56.2% of their urban counterparts). Approximately 4% of both groups of respondents claimed that they ever had sexual intercourse with prostitutes. Both groups of samples had the same tendency of sexual orientation of heterosexuality (97.8% and 96% of rural and urban respondents, respectively). Table 2 shows the low involvement of men (fathers) in reproductive health and domestic chores and the statistically difference between the two groups ($t = 2.42$; $p < 0.005$).

Table 2 – Men's role as father in reproductive health & domestic chores

No.	Types of Role	Urban		Rural	
		N	%	N	%
1	Discussing the methods of contraception with the wife	259	54	201	42
2	Accompanying the wife during the prenatal care	379	79	417	87
3	Using a condom	43	9	24	5
4	Accompanying the wife during the childbirth	422	88	446	93
5	Taking a leave when the wife gave birth	216	45	268	56
6	Performing domestic chores while the wife was giving birth	321	67	374	78
7	Having sex with one partner for life	364	76	427	89
8	Supporting the wife for a *pap smear*	163	34	110	23
9	Coercing the wife for sex	124	26	91	19
10	Helping with domestic chores while the wife was menstruating	187	39	321	67

Source: Analysis of Primary Data, 2014

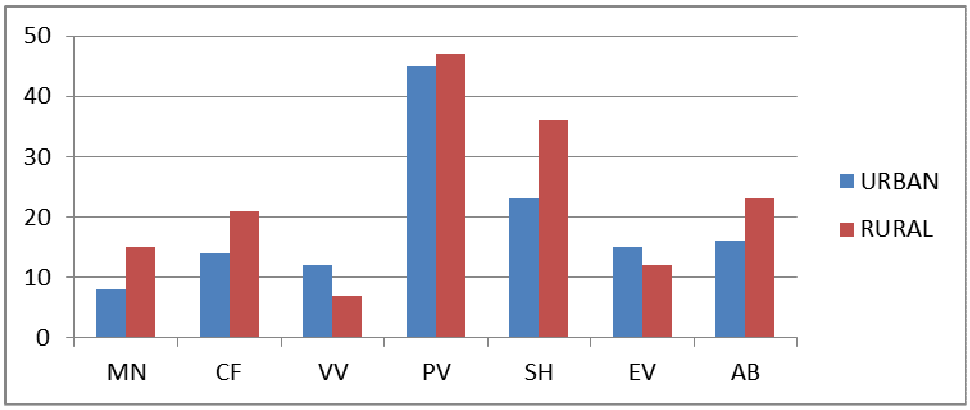
3.2. Childhood Trauma

A variety of factors is thought to be associated with gender justice, such as intimate relationships, family dynamics, social vulnerability and male health (Barker *et al*., 2011). Several other studies have also found an association between traumatic childhood violence and gender-based difference in child-rearing practices (ibid). The IMAGES (Barker *et al*., 2011) found the relationship of various factors with gender justice. One of these was job-related stress. The survey found that men experiencing job-related stress were more likely to engage in violence against their partners. Education and marital status were also found to be associated with gender-equitable attitudes. Educated and married men had more gender-equitable attitudes than their less educated and unmarried counterparts.

Childhood experience, including traumatic childhood violence, is associated with gender-based difference in childcare attitudes and behaviors. Information on childhood trauma was also explored in the present

study. Childhood trauma was measured using seven (7) items (indicators): (a) before I reached 18 years old, I did not have enough meals = MN; (b) before I reached 18 years old, changed family several times = CF; (c) before I reached 18 years old, I saw or heard my mother being beaten by her husband or boyfriend = VV; (d) before I reached 18 years old, there were members of my family who scolded me lazy or stupid or weak = PV; (e) before I reached 18 years old, Someone touched my buttocks or genitals or made me touch them on the genitals when I did not want to = SH; (f) before I reached 18 years old, I was insulted or humiliated by someone in my family in front of other people = EV; (g) before I reached 18 years old, I was beaten at home with a belt or a stick or whip or other hard objects = AB.

Figure 1 – Respondents' Childhood Trauma



Source: Analysis of Primary Data, 2014.

Despite the small figures, the percentage of respondents with childhood traumas needed to be noticed. For example, approximately 12% of the respondents sometimes or often went hungry in their childhood. Furthermore, as shown by Figure 1, approximately 10% of respondents said that they sometimes or frequently heard or saw their mothers were beaten. It was quite alarming that several respondents said that they had childhood experiences of having been beaten with a belt or stick. It occurred in both rural and urban respondents. Overall, results of statistical analysis showed that there was no significant difference in childhood trauma between urban and rural areas (t = −1.94382). The trauma most often experienced by respondents was being scolded/insulted by other family members (45% and 47% for urban and rural areas, respectively), followed by sexual harassment and physical violence of being beaten with a hard object such as a belt or stick.

Childhood trauma was the confounding variable of gender-based violence in the domestic sphere. Another confounding variable was the attitude toward male–female relationships. In the present study, the attitude showed the pattern of biased gender relations that was still firmly rooted in the communities. Physical or mental violence was still quite prevalent both in rural and urban communities. As shown by the above patterns of confounding and output variables, there was no significant difference between rural and urban respondents. Percentage of urban and rural respondents who had ever, sometimes or often 'scolded' their partners was quite high (28–35%). The same pattern was seen for the behavior of 'threatening to hurt'.

Table 3 – Intimate relationships: Decision-making and sharing of domestic chores

Aspects of Intimate Relationships		Rural (%)	Urban (%)
Family health-related decisions	Yourself	6	4
	Wife/partner	29	25
	Both of you	65	71
	Other people	0	0
Decisions related to buying expensive goods	Yourself	27	29
	Wife/partner	4	3
	Both of you	69	57
	Other people	0	1
Cooking and preparing food	Only me	2	3
	Usually me	1	7
	Equally	20	17
	Usually the partner	52	49
	Only the partner	25	23
	None	0	0
Childcare	Only me	0	2
	Usually me	0	1
	Equally	52	63
	Usually the partner	44	47
	Only the partner	4	7
	None	0	0
Frequency of quarrelling	Almost never	34	37
	Sometimes	64	58
	Often	2	5
I was very upset when my wife asked me to use a condom	Strongly agree	4	0
	Agree	40	51
	Disagree	56	49
It's me who determines with whom she may associate	Strongly agree	3	2
	Agree	35	29
	Disagree	52	59

Source: Primary Data Analysis, 2014.

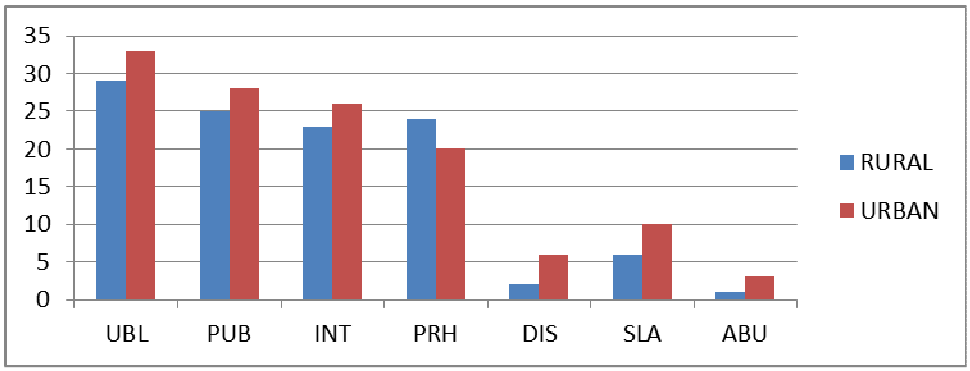
Results showed that childcare was mostly a shared responsibility of the husband and wife. Childcare was generally carried out flexibly according to the daily activities of the husband and wife. This was not apart of the activities to earn a living for the majority of respondents who were farmers in rural areas and temporary workers in urban areas. In addition, the involvement of the extended family members, such as grandparents and close relatives, was also significant in childcare. The sharing of childcare role by husband and wife was in line with the important decision-making patterns in the family such as those of education and children's future as well as the purchase of expensive items. In this case, male dominance was not noticeable. However, in other aspects, such dominance was evident as for example in terms of sexuality (condom use), decision of the wife's association and the frequency of husband–wife quarrelling.

3.3. Acts of Violence

The types of violence observed in the present study included: (a) scolding (insulting) the partner = UBL; (b) insulting/degrading the partner in front of others = PUB; (c) threatening to hurt = INT; (d) prohibiting the partner to work = PRH; (e) evicting the partner from home = DIS; (f) slapping = SLA; and (g) engaging in other acts of physical assault (kicking, dragging, beating, choking, etc.) = ABU. The most frequently

performed act of violence was scolding (insulting) the partner (29% and 33% in rural and urban areas, respectively). The most rarely performed act of violence was physical assault, such as kicking, dragging, beating, choking, etc. Other acts of physical violence, such as slapping the partner, were also relatively rarely performed (only 6% and 10% in rural and urban areas, respectively). Thus, the acts of violence perpetrated were more of psychic violence. There was a difference in male violence between rural and urban areas ($t = 2.645$; $p < 0.005$). The acts of violence were relatively higher in urban areas than in rural areas.

Figure 2 – Respondents' Violence



Source: Analysis of Primary Data, 2014

The high prevalence of male violence against their partners shows unequal gender relations in communities in addition to the deeply-rooted patriarchal culture in both rural and urban communities. If the perpetrators are mostly men, it is quite logical that reduction or prevention of violence starts from men. According to Flood (2013), the feminists have a theoretically powerful explanation for the increase in men's role in eliminating violence against women. First, and most importantly, efforts to prevent violence against women should be directed to men since most abusers are men. Thus, in order to make progress towards the elimination of violence against women, it takes efforts to alter male attitudes, behaviors, identities and social relationships. Second, the construction of masculinity plays an important role in shaping violence against women both at the level of individual, family and community as well as the society as a whole. Masculine attitude constitutes one of the factors in addition to male dominance itself. Male dominance in family decision-making is the strongest predictor for violence against women.

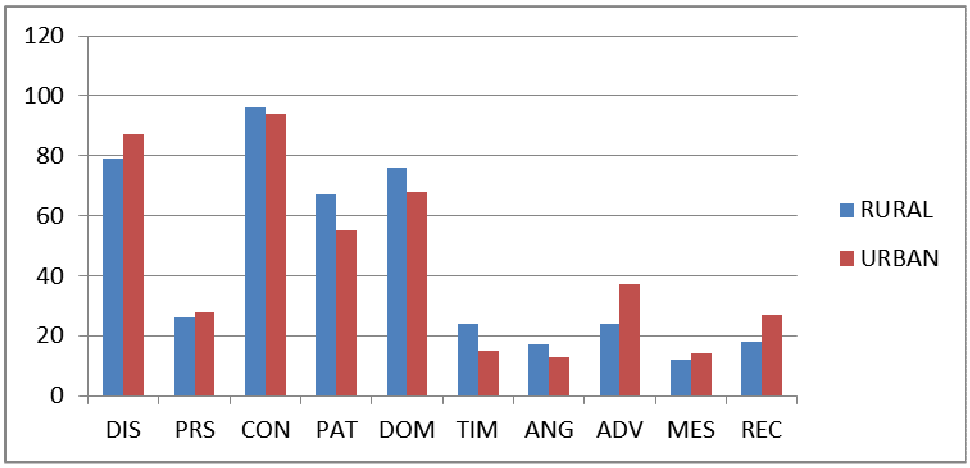
3.4. Prevention of Violence

Efforts to involve men in preventing and/or eliminating violence constitutes a formidable challenge since it is culturally against the evolving "mainstream" of culture in addition to having to change the mindset from "violence as an instrument of male domination" to "violence merely exacerbating the problems". Reconstruction of masculinity is also important in order for men to have a new critical awareness that the true man is one who cares (especially for the partner and family). To date, there is a masculine value orientation that domestic chores are women's domain and men's main task is as the breadwinner (financial affairs). These changes require extra hard efforts. According to Hill & Hill (1990), an increase in male paternal investment in childcare, for example, requires the strengthening of paternal motivation or necessitates coercion.

The study by Morrell and Jewkes (2011) showed that the reconfiguration of masculine identity and values was needed to achieve broader changes. Men emphasizing the emotional dimension in childcare generally showed better gender equality attitudes. The focus of efforts to change men through childcare should guarantee the equality of gender relations in the promotion of human rights, empathy and emotional involvement, rather than merely fulfilling the obligation.

The present study used 10 indicators to measure men's role in the prevention of violence: (1) discussing domestic problems with the wife = DIS; (2) speaking of personal issues with children = PRS; (3) playing/doing activities with children = CON; (4) teaching patience to children/wife = PAT; (5) teaching domestic chores to children = DOM; (6) performing the technique of "time out" when angry = TIM; (7) performing other techniques in controlling angry = ANG; (8) asking others for advice or assistance (consultation) = ADV; (9) Eating with family at least 5 times/week = MES; and (10) recreation with family at least once/year = REC. In general, there was a difference in measures of violence prevention between rural and urban men (t = 3.3166; p < 0.005). Some significantly different statements were: statements 1, 4,5,6,8, and 10. Rural men were generally more intensive to teach patience to their children/wife. Meanwhile urban males tended to be more intensive in discussing domestic problems with their wife, teaching domestic chores to children, performing the technique of "time out" when angry, asking others for advice or assistance (consultation) and recreation with family at least once/year.

Figure 3 – Men's role in the prevention of violence

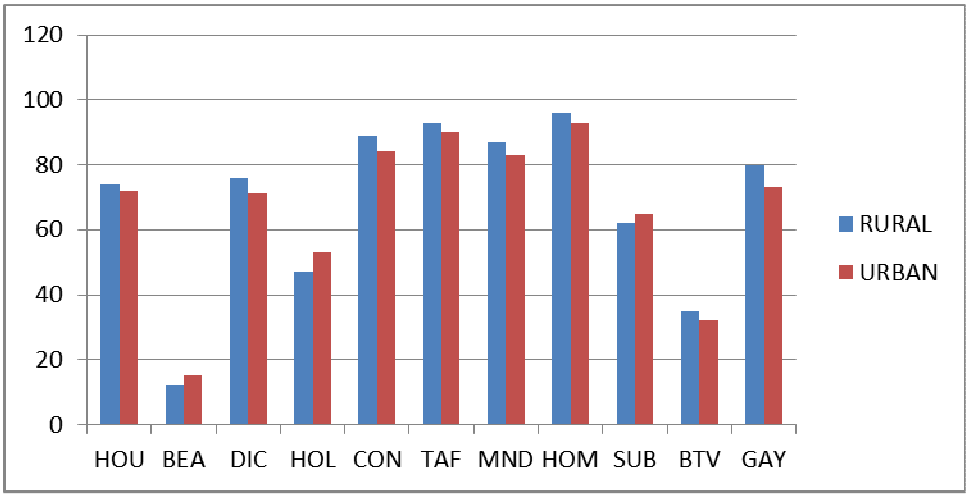


Source: Analysis of Primary Data, 2014.

3.5. Masculinity

In the present study masculinity was measured using eleven indicators of attitudes towards the statements of: (1) The most important task of women is taking care of the house and cooking = HOU; (2) women may sometimes be beaten = BEA; (3) men is the ultimate decision maker = DIC; (4) women should endure violence to keep the family intact = HOL; (5) equal right to decide the type of contraception = CON; (6) men must be tough = TAF; (7) everyone should be treated equally = MND; (8) men participate in domestic chores = HOM; (9) women must obey their husband = SUB; (10) if a woman is raped, it is usually she herself who caused it = BTV; (11) would be very embarrassed if having a gay child = GAY. In general, of the eleven indicators, there is no significant differences between rural and urban areas (t = 0.65653). However, there were significant differences in some aspects of masculinity, for example, the attitude towards statement 4 (women should endure violence to keep the family intact), statement 6 (men must be tough), and statement 11 (would be very embarrassed if having a gay child). Urban men were more likely to agree statements 4 and 6, while rural men were more likely to agree statement 11.

Figure 4 – Respondents' Masculinity



Source: Analysis of Primary Data, 2014

4. Discussion

Lack of knowledge of reproductive health and less supportive health attitudes and behaviors present problems in the efforts to increase male involvement in reproductive health. Results of the present study were consistent with those of Kululanga *et al.* (2012), which showed that male involvement in health facilities was fragmented and related mainly to the first birth, counseling and HIV testing of the partner. Male participation in health maintenance was influenced by socio-cultural obstacles centered on traditional beliefs and gender roles. These obstacles include the notions that pregnancy was "women's business" and that men's main role was the breadwinner. Men's role in antenatal care was only to drive the wife to the healthcare facility and not to accompany her, thereby not knowing the health problems faced by the wife. The role of accompanying the delivery usually only occurred at first-child birth. Lack of public accessibility to health services also occurred, especially in remote areas.

The low male involvement in reproductive health was indicated by the health-seeking behavior. Most respondents still felt reluctant to seek healthcare services. In this case there were many barriers preventing men from seeking healthcare services. This finding was in line with that of Malcher (2009), which suggested that the provision of healthcare services should pay attention to the needs of particular men. Meanwhile, Katz *et al.* (2007: 21) argued that there was a lot of evidence confirming barriers to parents to accessing health services. Several barriers were experienced by all parents and several other barriers were faced only by certain groups of parents or individuals in the communities. Some parents were even resistant to the health service or not aware of the services available.

The minimal male engagement in reproductive health was proportional to their low involvement in domestic chores. This study showed that 10–20% of men were involved in domestic chores such as cooking, washing clothes, childcare and so on. The low male engagement in domestic chores was inseparable from the deeply-rooted patriarchal culture in communities. Domestic chores in the context of a patriarchal culture were again seen as women's domain. The main duty of men was just to be the bread winners and not dealing with domestic chores.

The deeply-rooted patriarchal culture influenced the construction of masculinity in communities. One of the prominent attitudes was that women should be obedient to their husband. This attitude showed that women had a lower position than men and, as a consequence, had to obey their husband in any condition. In addition, this attitude constituted the justification for violence perpetrated and for the right to make decisions in the household. Another attitude showed that men were more likely to blame the victims. It was reflected in the attitude toward the statement that if a woman was raped, it was usually she herself who caused it.

Therefore, violence is something considered as "reasonable" for men to perpetrate, leading to men's minimal prevention of violence. Of the eleven indicators measured in the study, there were only two indicators that scored higher: the first indicator (discussing domestic problems with the wife) and the third indicator (playing/doing activities with children). Thus, efforts to involve men in the prevention of violence remain facing a formidable challenge of resistance not only from men but also indirectly from women who are part of a patriarchal culture. Unconsciously, women contrarily "support" the preservation of patriarchal culture while maintaining the social norms unfavorable to their lives. Women are more likely to avoid social stigma related to male engagement and prefer doing domestic chores for the sake of maintaining their husband's "good reputation".

5. Conclusion

In general, there were significant differences between rural and urban areas in terms of reproductive health knowledge, attitudes and behaviors; gender-based violence; men's role in reproductive health and domestic chores; as well as measures of violence prevention. Reproductive health knowledge, attitudes and behaviors of urban communities were better than those of rural communities. The acts of violence were more prevalent in urban areas with a lower intensity of violence prevention than those in rural areas. There was no difference between rural and urban areas in terms of confounding factors such as childhood trauma and intimate partner relationships. Similarly, this was the case with the construction of masculinity.

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