

WHAT IS THE COST OF BEING A MAN? : AN ANALYSIS OF SOCIAL AND HEALTH CONSEQUENCES OF MASCULINITY IN NIGERIA.

BY

Clifford Odimegwu¹, Christian Okemgbo², and Saseendran Pallikadavath³

- 1. Demography and Population Studies Program, University of the Witwatersrand, South Africa.**
- 2. Dept of Demography and Social Statistics, Obafemi Awolowo University, Nigeria**
- 3. Opportunities and Choices Reproductive Health Research Program, University of Southampton, Southampton S017 1BJ, UK**

Paper prepared for presentation at the XXVTH International Population Conference, IUSSP, Tours, France, 18-23, July 2005

SESSION NO. 110: Male Fertility and Sexual Behavior

EMBARGOED!!!

Abstract.

This paper presents findings from a pilot study focusing on men's perceptions of gender-role ideologies and their sexual and reproductive health. The objective was to examine how gender role ideologies and practices impact on men's social and health well being in South Eastern region of Nigeria. Data from adolescent and adult men aged 15-75 were collected in this study between April and June 2003 using both quantitative survey interviews (N= 1,372) and qualitative techniques such as focus group discussion (N = 20), in-depth interviews (N= 10) and key informant interviews (N=10) in selected parts of South Eastern Nigeria. We collected data on basic socio-demographic variables, attitudinal questions on gender role ideologies, sexuality issues, HIV/AIDS knowledge, awareness and practices. Our analysis shows that there are social and health costs associated with adherence to masculine ideologies among the Igbo of Nigeria. The study found a strong association between masculine ideologies and men's health, risk-taking and health-seeking behaviors. Implications of the findings on reproductive health service delivery are highlighted.

Introduction

Since the ICPD of 1994 in Cairo, Egypt, population and development programs and policies have increasingly adopted a reproductive health approach. The shift has had important consequences for the ways in which men are conceived of as participants in sexual and reproductive health. On the one hand, men are seen as important influences on the reproductive health of others (Dudgeon, 2003, Mundigo, 1998).

While reproductive health needs of men have finally been placed squarely on the research and policy agendas, there are many unanswered questions about what constitutes male reproductive health as well as the best ways to achieve it. Increasingly it has been recognized that there is need to understand more qualitatively male involvement in reproductive health, as well as men's reproductive health problems (Mbizvo, 1996). Because societies privilege men, they structurally affect the reproductive health of others, in ways that women do not: namely through the positions of authority they occupy, resources they control and the sexual and reproductive norms that they support or subvert (Dudgeon, 2003). Thus since 1994, there has been a renewed recognition of the role of men in the reproductive and sexual health of women and the importance of including them in programmatic efforts. (Eschen et al, 1999; Hawkes, 1998, JHUCCP, 1999, Danforth and Green, 1997, Drennan, 1998, IPPF/RHO/AVSC, 1998, AGI, 2002; Courtenay, 2000; Sabo and Gordon, 1995; Hull, 2000 and RHO, 1999).

Nevertheless, little is known about men's perception of their social and health needs. While it is generally acknowledged that gender-based customs and ideas promote men's behavior, there is a notable lack of research on men's understanding of these gender issues and how they impact on men's social and physical health (Eschen et al, 1999; Hawkes, 1998, JHUCCP, 1999, Danforth and Green, 1997, Drennan, 1998, IPPF/RHO/AVSC, 1998, AGI, 2002; Courtenay, 2000; Sabo and Gordon, 1995; Hull, 2000 and RHO, 1999). Men's studies in Nigeria and elsewhere especially in sub-Saharan Africa, however, have examined male role from the prism of deficit: *men need to do more to participate in preconceived sexual and reproductive health programs* (SSRH, 1999; Feyisetan et al 1998; Ezeh, 1993; UNFPA, 2001). Over-emphasis on male

involvement in women's reproductive health has led to an oversight of men's health needs. This is a major shortcoming of existing studies.

Individual and collaborative studies on gender-based violence in several settings in Nigeria (Odimegwu et al 2002; Odimegwu 2002; Okemgbo et al 2001; Kuteyi et al, 2001), women's perception of reproductive morbidities (Kuteyi et al, 2001) and male role in emergency obstetric care (Odimegwu et al 2002) in conjunction with a series of community-based seminars on the elimination of gender-based violence highlight the importance of understanding men's perceptions of cultural beliefs affecting their health. In most of these, there is a failure to demonstrate how gender inequities affect the health of men. Interventions having to do with maternal-child health, contraceptive use and decision-making or reproductive health problems have traditionally excluded men. The exclusion of men can be explained by factors such as limited resources (human, material and financial), men's lack of involvement and interest in reproductive health and (Collumbien and Hawkes, 2000). Much of the interventions are also externally driven.

While men acknowledge that they have a role to play in their partners' health, they enjoined researchers to *'to hear from us because we have health problems too'* (Odimegwu et al 2002). What has emerged from these studies is the need to study men, their perceptions of masculinity and its impact on reproductive health. Different approaches to promoting men's involvement in reproductive health reflect the fact that men are seen as primarily a 'problem' or a means to an end. This over-simplistic view of males has no doubt made men averse to participating in these programs. The result is that a mass of men in public and private places is not attracted because they are accused of irresponsibility with few promises of benefit to them (Hull, 2000). Although men are used as research subjects, researchers neglect to examine men's health risks due to their gender role ideologies. Rather than understand what men believe and feel and their health problems, they have often been studied from the perspective of what we could learn about them in order to convince them to participate in preconceived women's sexual and reproductive health programs.

This paper will explore men's perceptions of masculinity and its impact on their well-being. Understanding men's reproductive health need required framing men's health and well-being within local context. The promotion of gender equality and equity, a central policy goal of ICPD, cannot be achieved if the needs of males are neglected. (Barker, 1999; 1996; Keijizer, 1995, Stillion, 1995; Keijizer, 1995;Canetto, 1995; Mbizvo and Basset, 1996, Dudgeon 2003, Lorber 1997; Moynihan, 1998; Sabo and Gordon 1995, Sargent and Brettell 1996).

Men's perception and understanding of the relationship between gender role ideologies and health in sub-Saharan Africa, where cultural beliefs and values are accorded primacy are little un-researched. The effective role of males in gender equity and health promotion including the prevention of disease transmission requires a carefully designed effort to reach and educate men about the impact of gender inequities on their and their partners' health (RHO, 1999). Done correctly, this offers an effective means of promoting male involvement in reproductive health needs of their partners and achieving gender equity. Addressing sexual and reproductive health needs of men (e.g. infertility, STIs including HIV and access to contraceptives will benefit the man, woman, family and the society.

Therefore the two basic research questions in this study are (1) what are the traditional and current perceptions of masculine ideologies? (2) What are the social and health consequences of such ideologies? It is our conviction that raising awareness of men's health risk as a result of gender inequities is a sure way of promoting effective and sustainable male involvement in gender and reproductive health programs. The overall goal of this study is to increase an understanding of how men's perception of the impact of the social construction and expression of masculinity in their well being in a Nigerian ethnic group.

Literature Review

Since 1994, studies on men have received increased attention. These include studies focusing on men's involvement and responsibility in reproductive and sexual health of women (Mundigo, 1995, UNFPA, 1995; AGI, 2002, Omideyi et al 1999, Feyisetan et al

1999, Bankole and Singh, 1998, Odimegwu et al 200). One major conclusion from all these studies is the need to promote male involvement in reproductive health activities.

Emerging studies have reported on the connections between gender and health of men (Sabo and Gordon, 1995). These argue that numerous aspects of health, ranging from accidental deaths to cardiovascular disease are conditioned not only by differences between male and female physiologies but also by the culturally specific, socially constructed gender roles and identities that men and women perform. Courtenay (1998, 2000) has posited that there is a reciprocal relationship between masculinity and health, stressing that men's health problems are often produced by men's enactment of masculinity, and that cultural norms and expectations reinforce these enactments. Other researchers have reported some illnesses to be un-masculine, and some disorders such as infertility and erectile dysfunction as un-masculine (Inhorn, 2002, 2003b). There are particular masculine sexual behaviors that are unhealthful for both men and women, and these include sexual promiscuity (Farmer et al 1996), avoidance of contraceptive use (Ward et al 1992).

Maskowski (1999) and Unruh et al (1999) have reported that men are less likely to discuss experience of pain or physical distress. Men report less pain for the same pathology, less severe pain, greater tolerance of pain and shorter duration of pain. Moreover, men have been found to report less pain in front of female health professionals than male health professionals (Levine and DeSimone 1991; Puntillo and Weiss 1994). Emotional inexpressiveness of men has been blamed on traditional masculinity. The reluctance to acknowledge or report physical and emotional distress can have far-reaching implications for men's health as it can influence health-seeking decisions, delay intervention and undermine diagnosis and treatment planning (Courtenay 2003). Masculinity is not all negative. Positive masculine characteristics include ability to act independently, to be assertive and to be decisive. Reliance on these helps men to cope with some difficult moments (Sharpe et al 1995; Charmez 1995). In terms of expression of emotions, physical distress, men report less fear or emotional distress but more likely

to express anger than women (Courtenay, 2001a). The inexpressiveness of men has been reported to have direct and indirect effects on their health and well-being

Though there has been a realization of the need to engender health, the result has been an exclusive emphasis on women and 'gender and health' has become synonymous with women's health (Sabo and Gordon, 1995; Courtenay, 2000). While men have been used as research subjects, they are neglected in research, as there are few studies to examine men and the health risks associated with men's gender especially in Africa. The health risks associated with masculine gender have largely remained uncharted. Even in studies that address health risks more common to men, the discussion of men's greater risks and of the influence of men's gender is absent. This study therefore examines how masculinity is perceived and its impact on social and physical well being among the Igbo of South East Nigeria

Theoretical Framework.

Explanations of masculinity and men's health have focused primarily on the hazardous influences of the male sex role (Courtenay, 2000; Harrison et al 1992). The sex or gender role theory posits that boys learn to adopt masculine behaviors that in turn heighten their susceptibility to illness or accidental death. This theory holds that social environments from the level of culture down to individual family and peer relationships, teach men and women to display distinct sex-typed behaviors and attitudes. Pleck (1981, 1995) posited that this teaching is accomplished through the adoption of norms and stereotypes. Norms are prescriptions for how men and women should behave, while stereotypes are generalizations about what men and women are like and can do.

Masculinity ideologies are ideas and concepts that individual men hold about what it means to be a man. The study of masculinity ideologies is concerned with the extent to which men endorse ideologies that emphasize self-reliance, competitiveness, emotional control, power over others, and aggression (Pleck et al 1993). For example, a man might believe that men should keep their emotions under control, and that by extensions; they should not be emotional when under stress. Alternatively, endorsement of masculine

ideologies might involve a man's devotion to self-reliance in the face of hardship, a belief that competition in professional and social domains is crucial for success, a strong preference for resolving conflicts with aggression so as not to appear feminine or a desire to demonstrate dominance and power over others in social interactions. Additional health beliefs and behaviors that can be used to demonstrate masculinity include the denial of weakness or vulnerability, emotional and physical control, the appearance of being strong and robust, dismissal of any need for help, a ceaseless interest in sex, the display of aggressive behavior and physical dominance. In exhibiting masculinity, men reinforce strongly held cultural beliefs that men are more powerful and less vulnerable than women; that men's bodies are structurally more efficient than women's bodies; that asking for help and caring for one's health are feminine and that the most powerful men among men are those for whom health and safety are irrelevant. (Courtenay 2000).

According to this framework, males use health beliefs and behaviors to demonstrate dominant and hegemonic masculine ideals that clearly establish them as men. Hegemonic masculinity is the idealised form of masculinity at a given place and time. It is the socially dominant gender construction that subordinates femininities as well as other forms of masculinity, and reflects and shapes men's social relationships with women and other men. It is in pursuit of power and privilege that men are often led to harm themselves. The social practices that undermine men's health are often the instruments men use in the structuring and acquisition of power. Men's acquisition of power requires, for example, that men suppress their needs and refuse to admit to or acknowledge their pain (Kaufman, 1994 in Courtenay 2000).

Subscription to traditional masculinity ideologies may influence men's health –seeking patterns. For example, men with traditional masculinity ideologies may deny or refuse to seek help for pain, illness, or emotional problems in an effort to avoid being perceived as vulnerable or weak (Kaufman, 1994, Mansfield 2003). Thus adherence to traditional masculinity ideologies may be hazardous to men's health. (Mahalik et al 2003, Harrison et al 1992; Stillion 1985). Sabo et al (1986) tapped sex-role theory to explain the psychosocial reactions and adjustments of male partners of women who had been

diagnosed and treated for breast cancer. Other studies have been done using this theoretical framework (Nix and Lohr, 1981; Degregorio and Carver 1980; Cummings et al (1983)).

This framework has been criticized as implying that gender represents “two fixed, static and mutually exclusive role containers” (Kimmel, 1986 in Courtenay, 2000) and for assuming that women and men have innate psychological needs for gender-stereotypic traits. Sex role theory, Courtenay (2000) reported, also fosters the notion of a singular female or male personality, a notion that has been effectively disputed and obscures the various forms of femininity and masculinity that women and men can and do demonstrate.

Igbos and Masculinity

Igbo land is the home of the Igbo people of South East Nigeria. The area is divided into two unequal parts by the River Niger. One part is the eastern region made up of the five Igbo-speaking States of Anambra, Enugu, Abia, Ebonyi and Imo States. The other part is in the midwestern region of Nigeria, and is located within the present Delta State. For the ethnic group, personal advancement and participation in local affairs are matters of individual initiative and skill. Success, eldership, wealth, a good modern education, political power and influence are all ways by which the Igbo people could distinguish themselves.

Achebe (1958) in his seminal work, *Things Fall Apart*, has provided a glimpse of the Igbo traditional gender norms and values. A boy's father will do everything to ensure that there is no trace of feminine trait in his son. Achebe in this work showed how through informal education, boys are groomed to be men, bold, courageous, audacious and fearless. On the other hand, the women groom their daughters on how to be soft, subservient, passive, weak and gentle. This silent but rigorous schooling into the individual gender stereotypes are ingrained in the Igbo institution. Each of the sexes knows what is expected of him or her. Ozumba (2005) suggests that men and women in this area seem to have accepted their gender roles as a *fait accompli*.

In the family, women sweep the house, wash the plates, cook the food while the men split the firewood, pound the yam, and climb the palm trees. In farming, the women plant maize, melons, beans and cassava while the men made the yam mounds. Yam stood for manliness as it is regarded as the king of the crops (Achebe, 1958). In traditional Igbo society, a man is known by how many mounds of yam he has acquired (Uchendu, 1968).

Among the Igbo, women's image is that of one who enjoys the labour of men. They are called '*oriaku*', meaning enjoyer of the wealth of their husbands. In the family if a child is born, the sex is determined and if a boy, that means a bundle of joy to the parents. For the man, joy, because he has a man who will take his place after his death and continue the family lineage. It is joy for the mother because that will properly entrench her in her husband's heart. Having a male child means nothing can uproot her from the family and means also that she has a voice in the family. But if the child is a girl, the husband and wife receive it with mixed feelings, especially if the woman has more than three consecutive female children. For the man it brings sorrows because his hope of having a male child to continue his lineage is becoming slimmer.

As the children begin to grow, the males and females are socialized differently. The boys are socialized to see themselves as superior, stronger, more important and indispensable. The females are trained to act as appendages of the men. Fathers tell their sons stories of violence and bloodshed to toughen them and prepare them for future roles as the protector, guardian and head of their families. On the other hand, the mothers tell their daughters feminine stories about how to behave themselves so as to attract good men as future husbands.

Gender-roles are clear-cut that the males getting into the areas meant for females and vice versa are regarded as abomination. The boys' duty ranges from washing his father's clothes, taking care of the flock, getting knives and axes sharpened; leads in the way to the farmlands, protects the girls, ensures that the difficult tasks are done. While the male child is not restricted, the female is not. (Achebe, 1958, Ozumba, 1995, 2005, Achufusi, 1994). Gender role ideology is well ingrained in Igbo society.

Methodology.

The study was conducted in Imo State, located in the Southern part of Nigeria. All of the participants are Igbo, the third largest ethnic group in Nigeria. The data collection sites are Owerri, the State Capital and Orsu, a typical rural area. To understand the social and health costs associated with adherence to ideologies about masculinity, both qualitative and quantitative approaches to data collection are used. The research design is a descriptive formative research. This was used because we wanted to generate enough concepts to be used in the design of the instruments eventually used for the study. The data were collected in two phases. Qualitative data collection techniques were used during the first stage and quantitative approach during the second.

Qualitative information came from focus group discussion (N=20) sessions or interviews, in-depth interviews (N=10) with community or opinion leaders and health care providers in the communities. The selection criterion for the focus group discussions was that the potential participant must be resident in the selected research site. Individuals invited to participate in the group discussions were those perceived as most likely to provide the most useful information. Twenty focus groups (10 in each location) consisting of between 6 and 8 individuals were run. These were organized around four age groups, namely 15-24 (young males), 25-39 (young adults), 40-54 (middle-aged groups) and the elderly group (55+). In each research site, group participation was based on similarity with respect to age, education and occupation.

During the sessions, all the participants made contribution to the discussions. At times there were dominant speakers but session organizers/moderators were trained on how to handle such participants. When other participants were given opportunity to talk, passive respondents tended to support the dominant opinion. At the end of each question, the moderator summarized the main points of the discussion, and made sure the participants subscribed to it to arrive at a consensus of opinion.

Before the study started we explained to the traditional leaders of the areas the purpose of our research. Based on the criteria already discussed with research assistants, those who

were asked to participate in the group discussions were those perceived as likely to provide the most useful information. The average age of participants was 44.5 years, and the size of the focus groups ranged from 6-8 men (adolescents and adults). Group discussions centered on men's perceptions and beliefs regarding masculinity, awareness of and attitudes toward gender-based ideologies and practices in Igboland. Also discussed were sexual and reproductive health needs of men and their relationship to masculinity. Specifically, we sought information on their knowledge of and attitude towards women's empowerment and their involvement in reproductive health program. Finally we discussed how men would be involved in reproductive health services especially as it affects men. Average duration of each interview was 90 minutes. All the interview sessions were tape-recorded. At the end of the sessions, a research assistant employed for that purpose transcribed the taped cassettes.

In-depth interviews were conducted with individuals considered as key informants. These included adolescents, health care providers and opinion leaders in the communities. A total of ten (10) in-depth interviews (5 urban and 5 rural) were done. Among adolescents, the selection criterion was reported sexual activity or expression of stronger gender identification with masculine ideologies. In-depth interviews also focused on the same issues as discussed in the FGDs. In order to gather information on the health needs of men, in-depth interviews were also conducted with a traditional health worker, a laboratory scientist and a chemist/pharmacist, a medical doctor and a male nurse.

Quantitative

A series of steps were taken to select potential participants during the second data collection stage. Enumeration of households by type of residential zone took place at the first step. Owerri was divided into traditional area, migrant area and government reserved estates. Traditional zones are inhabited by poor indigenes. Medium income earners who are mostly migrants to the urban center inhabit migrant zones. Top government officials and *nouve riche* inhabit government reserve estates. Orsu, the rural area, is homogenous in terms of culture but socio-economically diverse.

Sample size selection

Simple and stratified random sampling procedures were used to select the participants during this phase. In the capital, stratified random sampling procedure was used. The size from each stratum was based on probability proportionate to size in order to gain representativeness. Systematic random sampling was then used to select potential participants from selected households. Since Orsu is ethnically homogenous, a simple stratified random sampling strategy was used in selecting rural respondents. A total of 1,372 respondents were eventually sampled and interviewed. It was easy for this complex approach to be adopted because during the qualitative data collection exercise, we established rapport with community members. Moreover, we recruited male residents of the areas as research assistants. This greatly facilitated the data collection process.

The research instrument included several questionnaires in different sections. The questionnaire included items about the background characteristics of the respondents: age, education, and religion. It also consists of twelve items that examine perceptions of gender roles at home, society and at work. Items include statements such as “The man has the final say in the house”, and “women should not earn same salary as men”. The scale of responses ranges from strongly agree (1) to 5 (strongly disagree). The questionnaire was validated in another study conducted by the first author (Odimegwu, 2002). The Cronbach’s alpha internal validity value for the questionnaire was 0.67. To determine if an individual adheres to masculine ideology or not, the responses were scored and means found. The higher the score, the more liberal the participants gender role ideology (referred to as non-traditional) while the lower the score the less liberal and hence regarded as traditional. The instrument also included items assessing health status, risk-taking behaviors (such as alcohol consumption, drug abuse and unprotected sex), awareness of STIs including HIV/AIDS and health-seeking behavior.

Data Analyses

Qualitative Data.

A thematic approach involving three stages was used to interpret the qualitative data. In the first stage, transcribed documents were read and re-read in order to generate explanations addressing the basic research questions. During the second stage, these were sorted into specific themes. The third stage is the systematic organization (coding) of the entire data and matching it with the relevant research questions. This allowed for an understanding of the extent to which the qualitative data generated information directly related to the primary aim of the study and provides explanations for the key findings from quantitative analyses.

Quantitative data

Three levels of analysis were conducted namely frequency, cross tabulations and multivariate. The multivariate logistic regression procedure was used to examine the association of masculinity with men's health status, risk-taking and health-seeking behaviors. Health status was assessed by whether the man has any serious illness during the year before the interview. Risk-taking behavior was evaluated by whether a man consumed alcohol or smoked cigarettes, pot or crack prior to engaging in sexual intercourse or if he did not use the condom always. Health-seeking behavior was measured by whether the respondent who has a serious illness during the preceding 12 months sought modern health care. Independent variables include age, place of residence, number of lifetime sexual partners, educational level, religious affiliation and masculine ideologies (measured by whether an individual holds traditional or non-traditional masculine ideas).

Findings

Profile of Respondents.

Approximately 59(58.9) percent of respondents holding traditional (gender) beliefs live in the rural area compared with 37 percent of those who live in the urban areas (Table 1). As evident, traditional masculine beliefs cut across all levels of education. Those with secondary or higher level of education are non-traditional than others. The table also

shows that adherence to masculine ideologies varies by religious affiliation, with Catholics showing more traditional beliefs than others. Majority of the respondents hold traditional masculine ideas (70%).

Table 1: Percent distribution of respondents by socio-economic characteristics controlling for type of masculine ideologies, South East Nigeria, 2005.

Characteristics	Masculine Ideologies		Total
	Non-traditional	Traditional	
Place of Survey			
Urban	63.1	41.4	53.1
Rural	36.9	58.6	46.9
Age			
15-24	15.9	24.5	20.0
25-39	20.0	26.5	23.0
40-54	40.4	28.9	34.0
55+	23.7	20.1	23.0
Educational Level			
None	2.2	3.0	2.6
Primary	20.8	28.2	24.5
Secondary	44.2	45.2	44.7
Tertiary	58.7	41.3	28.2
Marital Status			
Married	53.1	59.6	56.4
Divorced/Separated/Widowed	44.3	39.1	43.7
Religious Affiliation			
Protestant Orthodox	29.1	26.3	27.7
Catholic Church	58.1	60.2	59.2
Muslim	1.0	0.7	0.9
Evangelical	11.2	9.8	10.5
Traditional Religions	0.9	2.7	1.8
Media Exposure			
1 Source	52.5	48.2	50.4
2 Sources	92.9	91.4	92.2
3 Sources	84.1	83.8	83.9
Total	69.8	30.2	50.0

Perceptions of Masculinity

Focus group participants generally agreed that being a man in this ethnic group connotes a lot of meanings and challenges. In general, discussants endorsed the idea that a man is the one who takes responsibility, has a family (wife and children), possesses tangible items such as land and house, a player in the community, has recorded some achievements in life and does not exhibit any feminine traits. According to men aged 40-54 in a rural group discussion,

When you call me a man, I have a sense of a burden bearer, someone who defends and cares for others, who represents his father in lineage continuity. As a man I am expected to provide for my family, defend and represent it.

.... be a man of substance, endure a lot of difficulties without complain or showing signs of strain; able to give a wise judgment.

He should be entrusted with certain responsibilities like going into marriage, family affairs, financially viable and capable.

Young males added that “*Our idea of being a man is being independent, strong-willed, able to take and stand for decisions, responsible to ones immediate environment, not a gossip or talkative*”. [15-24 Males, FGD, Urban].

Furthermore, “*being a man goes with boldness, fearlessness, perseverance, diligence, handwork, integrity. You don’t just be a man in Igboland because of your penis or other physical features but by your ability to carry out challenges that come the way of a man*”. (Key informant aged 60, Rural).

Participants further reported that a man holds power and authority in his house; he does not betray his emotions when he is under stress nor is he irrational.

Sources of Masculinity

Participants agreed also that the socialization process of male children in the community starts from home via parents, peers, schools and churches, and in recent times, movies and televisions. Mode of transfer of knowledge includes storytelling, suggestions and disciplinary measures. The older respondents reported how their parents schooled them in those days in the act of being a man while the younger ones explained that they are still

learning from their adult relations, movies and media on how to be a man or the characteristics of manhood.

The family is the outreach center for boys to learn about masculine identities. He learns how to behave and act like a man at home. He is taught how to be tough, offensive or defensive, to succeed, to use excessive power and authority. It is the environment he finds himself that contributes to defining him as a man. [Adult male aged 45+, Urban, IDI].

Nonetheless, qualitative and quantitative data analyses both demonstrate changes in the mode of socialization. In the context of globalization and increasing exposure to and use of technology. According to the participants, the role of parents and other adults in knowledge transfer is decreasing. Other pressing demands like work, media listening and viewing among others are making it impossible to spend as much time on folk tales and the like which serves in transferring ideas about masculinity

Societal Expectations.

Society expects a man to be able to provide accommodation for his family, including his siblings and fulfill other social obligations. A man should be physically strong and is not expected to betray his emotions and be able to endure physical pain and discomforts. A man who does not show sexual interest in women is perceived to have a sexual or biological problem. Igbo society expects that a man will exercise power and authority over his household, including the dominance of wife (wives) and children. Although the males are expected to be the main decision-makers, the following serves to illustrate that some of them perceive a need for husbands (men) to listen to their wives (partners).

When there is a disagreement, you can call her and explain to her why you think your decision is better. Always avoid a third party. Even though she does not agree with the man, he is the one to take and implement the decision. If there is a disagreement you have to take the final decision because where there is blame, the man is held responsible... The man gives a final decision on how he wants his family to be run. [Men, aged 40-54, tertiary education, Urban FGD].

Achievement of Social Expectations

There are a number of ways in which Igbo men are able to demonstrate proof of masculinity. These include (1) marrying and having children, (2) building a house (3) having a male child (4) possession of achieved social titles (5) dominance over women (6) participating in and (7) contributing to community development. Married life is considered the normal condition in this society and marriage is a status conferring (Uchendu, 1968). A man who does not have a wife and or children faces social ridicule and castigation. An unmarried male is referred to as a male-woman, a pejorative term. A man with many wives is regarded as ‘ogaranya’, a man who is rich in terms of both money and people. Traditionally, among the Igbo, having many children is a sign of wealth (Uchendu, 1968, Odimegwu, 1998). Focus group participants, nonetheless, acknowledged that due to economic pressures, the association between wealth and high fertility is weakening. Among contemporary Igbo, the quality rather than quantity of children is emphasized now than before. Furthermore, an Igbo man could also use physical force to demonstrate power and authority and by possessing titles such as ‘nze’, ‘ozo’ as illustrated in Achebe’s seminal work, *Things Fall Apart*. For example, one elderly man points out that

Even the great hunters show their strength especially when they kill lion or have an incredible accomplishment, which earn them the title “ogbu agu” (killer of lion), or when a man is able to fight for his village.

Men also marry many wives to show that they are men and able to control a large family. Some men are given the title of “Osuji” because of their ability in yam cultivation, which the more yams you had, showed how rich you are.

[Men aged 55+, Rural FGD]

Polygamy and multiple sexual relationships, which were traditionally used as bases of power, are in the decline due to a number of factors such as religion, economic pressures and migration. Multiple sexual relationships are no longer encouraged because of the risks involved (STIs and HIV/AIDS).

Social Costs and Rewards

The social and physical costs resulting from adherence to traditional masculine ideologies were acknowledged by the majority of group discussants. One community leader observes that in community meetings or assembly *“you are denied recognition”*, and emphasized, *“in fact people trample on your rights because they know you cannot do anything because you have not guts”*. The pressure of ridicules, jokes and gossip often result in risk-taking behaviors such as smoking, drug abuse, alcoholic consumption and such health problems as suicide, heart attack, and high blood pressure. Most men adhere to masculine norms and beliefs because of the social ridicule and shame they portend. An elderly participant pointed out

Your mates will be making mockery of you because you cannot prove that you are a man. You have nothing to show for being a man. You will be object of jokes and gossips in the community. Your bigger family, that is, all relations of yours, will bear thee shame. They will say their brother is not a man, is a disgrace.

On the other hand, the reward for being a man involves social recognition and approval. The family and community will be proud of the man. It is commented by participants that this aspect of social approval has led to a situation whereby male folks in the community do a lot of things to demonstrate their masculinity so that they will win societal approval. However they noted that there is always a limit to these. Igbo society honors hard work and diligence borne out of sincerity but does not encourage laziness and shady deals.

Health Costs: Sexual and Reproductive Health Needs

In attempting to avoid the social costs of masculinity, many men have been infected with STIs, including HIV. Most of the participants attribute the current rates of HIV/AIDS in society to men’s attempt to demonstrate proof of masculinity. They feel that sexual double standards that empower males must be challenged in order to abolish this problem. However a few of the men noted that culture is overemphasized. They hold that culture has a moral prescriptive power – it recommends but does not enforce. They stressed that an individual man has a right to reject cultural prescriptions that compromise his health.

Furthermore, participants pointed out other health problems, which men suffer as a result of masculinity. These include heart failures, cancer, HIV, STIs, high blood pressure and suicides. They argued that in order to impress the society or initiate a false start, most men risk their lives by engaging in dangerous practices that are not healthy. According to the discussion, most men go extra mile to do some work in order to earn a living and meet up with societal expectations. One result of this excessive activity is that they most often fall sick. And because the society has taught them how to be tough and stoic in the face of pain, they hardly go for medical attention. When they do, it may be too late, resulting to death. Moreover, the participants reported that after the excessive activity by men, instead of taking care of their health, they might end up engaging in smoking and drinking excessively. These compromise their health further. Even though it is generally acknowledged that masculine ideologies are common among the Igbo, there is no sanction against any deviance from masculine traits, except the social cost of ridicule and shame.

If I do not do those things that we think make us men, nothing happens to me. If I do not womanize or drink or smoke or engage in hard labour or show stoicism or even meet the societal expectations of marrying, having children, building a house etc, nothing happens to me. There is no reason why our culture should be blamed of anything. Men should learn to be responsible for their action without blaming the culture. [IDI, Male, aged 45).

Participants identified a number of reasons why most men do not seek for health care such as financial constraint, ego, fear of stigma, ignorance, fatalism and others. Participants in one group pointed out that stoicism or emotional inexpressiveness might be due to pride.

The man is supposed to be defender, comforter and provider in the house. What happens when you see that man weeping or crying because of pains? It debases him or reduces his prestige level before his family members. He is supposed to be the general of the family's army and should not betray his emotions as it will affect his troops (family members) [Men, aged 40-54, Rural FGD].

Although most men do not seek health care early enough, participants noted that this is done for the sake of confidentiality and not necessarily because of masculine beliefs. Men often do not have enough sleep because of the pressure of the need to accomplish societal demand. They pointed out that most men spend time rolling on their beds thinking about

what to do in order to meet societal expectations. They argued that because of social demands, men find it difficult to stay in bed to recover from illness. One middle-age man explains

If I stay in bed longer than necessary, who will take care of my family? It is not that we do not know the value of these things, but circumstances force us to do some things that are inimical to our health. If you check your body and the case is not serious, you can get out of the bed. (Key informant aged 55, Urban).

There was agreement that some cultural practices expose men to health hazards. Men who are encouraged by society to have multiple sexual partners are more likely to engage in risk-taking including criminality. Participants were able to link such behaviors with the spread of sexual and reproductive health problems in the community as the following remarks show.

Yes there is a connection between these. When a young man knows he is of age and he begins to drink and smoke, he will feel he is a big boy. When he does these, he will think that when he sees a lady and talk to her, she will take him as a big boy. Anybody who drinks and smokes too much will likely go out after some girls. [Adolescents, aged 15-24, Urban FGD]

Drunkenness and sexual promiscuity are in common. Some men said when they are drunk, they feel high. It is then you see them going after girls, messing around with them. They believe if you don't drink or smoke, you do not belong. Some men even go to the extent of betting on their abilities to drink so many bottles of beer. After drinking they will now want a lady who they will want to use. Some girls even like guys who drink and smoke. [Middle-aged Men, 25-39, Rural FGD].

Although their health needs were never acknowledged, they pointed out that most men have special needs demanding attention. They however pointed out that a trip to hospitals and clinics and herbal homes would however highlight the magnitude of these problems.

Masculine Ideologies, Health Status and Risk-taking behaviors

Quantitative data analysis shows that health status and risk-taking behavior vary by masculine ideologies (Table 3). Over one-fourth of the men had a serious illness during the year before the interview. As the information shows, among those with a serious illness, in general, those who adhere to traditional beliefs engage in risky behaviors often than others do. Health status and risk-taking behaviors vary by masculine ideologies

Table 3: Distribution of respondents by their health status and risk-taking behaviors controlling for masculine ideologies, South East Nigerian 2005.

Health Status	Masculine Ideologies		Total
	Non-traditional	Traditional	
Serious Illness in preceding 12 months	27.4	52.2*	39.8
Risky Behaviors			
Smoked	51.0	62.9*	57.0
Age at first smoking	19.5	16.7	20.5
Current Smoking Habit -daily	38.6	42.7*	56.0
Consumed Alcohol	69.2	93.5*	81.4
Age at first alcohol consumption	22.5	18.5	20.5
Current alcohol consumption - daily	16.4	43.6*	23.0

* Significant at 95%

Masculine Ideologies and Sexual Behavior.

Most men interviewed have had sexual intercourse. The median age at sexual debut is 20 years and less than half (42%) used a method of contraception at that time (Table 4). It is evident that sexual activity, age at debut, and the use of birth control at sexual debut varies by masculine ideologies. It is also obvious that numbers of current and lifetime sexual partners also vary by masculine ideologies. Among those who have had sex with commercial sex workers (CSW), those adhering to traditional masculine ideologies are far more likely than their non-traditional counterparts not to use condoms during sex with CSWs.

Table 4: Distribution of respondents by their sexual behavior controlling for masculine ideologies, South East Nigeria, 2005.

Sexual Behavior	Masculine Ideologies		Total
	Non-traditional	Traditional	
Ever had sex?	96.2	98.4	88.2
Median age at first sex	22.5	19.2	19.9
Used contraception during first sex	49.5	15.7*	41.9
Mean number of sexual partners	2.1	2.6	1.9
Alcohol consumption prior to sex			
Always	15.8	5.3	5.9
Often	4.0	2.9	3.4
Occasional	40.8	49.8	43.0
Never	47.9	48.0	47.6
Sex with Commercial Sex workers	25.5	27.3*	26.1
Sex with CSW without condoms	14.7	45.3*	30.0
Lifetime sex partners	3.1	4.4	5.7

* Significant at 95%.

Masculine Ideologies and Health-seeking Behavior

A number of studies have found that men use health services and visit physicians less often than women but do so if they have a serious health problem (Eisler 1995). This study found that though cultural norms promote stoicism, there are limits to it. Among Igbo men, stoicism is related to age, type of illness and access to health care services. According to focus group participants, Igbo men seek health care if they are ill whether mild or serious but only when the illness is not the type with a stigma.

Participants agreed that men seek for health care services when they are sick. There are different types of health care options available. Men seek for health care when the

sickness is not the type with stigma. It was agreed that men most often do not disclose their illness in order not to shake the confidence of individual family members who depend on them for assistance and survival.

“Some go to native doctors because they believe native doctors (traditional health care practitioners) because they believe traditional healers can treat them better. Some people believe that whoever has gonorrhoea, syphilis or staphylococcus, and goes to a modern health care provider, he will only give him an injection to suppress it then after some months it will re-occur. That is why most infected people go to native doctors with the belief that these will give them medicines that cure it completely. Others visit prayer houses, pharmacy or herbal medicines. When these fail they resort to western orthodox medicine. [Men aged 40-54, Rural, FGD].

The choice of type of health care services is dependent on age of the person, belief systems, availability of funds, type and serious of illness.

Multivariate Logistic Analysis.

Table 5: Logistic model of predictors of association between masculine ideologies and men’s health status, risk-taking and health-seeking behaviors, South East Nigeria 2005.

Variables	Health Status (Ill in preceding year)	Risky Behavior	Health-seeking Behavior
A.Socio-demographic characteristics			
Age			
< 25	1.00	1.00	1.00
25 - 39	0.55	1.29	1.21
40-54	1.21	0.97	0.86
55+	0.30	0.89	0.87
Place of Residence			
Urban	1.00	1.00	1.00
Rural	2.67*	1.32	0.45
Number of Sexual partners	1.32	1.05*	1.78*
Educational level			
None	1.00	1.00	1.00
Primary	0.51*	1.69	7.90*
Secondary	0.39*	1.54	5.46*
Tertiary	0.58	0.10*	8.35*
Religious affiliation			
Protestant Orthodox	1.00	1.00	1.00
Catholic Church	0.74	4.34*	1.21
Muslim	0.69	1.38	1.32
Evangelical	0.58	3.16	1.45
Traditional Religions	2.11	5.08*	2.32

Media Exposure			
1 Source	1.00	1.00	1.00
2 Sources	0.89	0.76	1.34*
3 Sources	0.78	0.56	1.25*
Traditional Religions	2.11	5.08*	2.32
Masculine Ideologies			
Non-Traditional	1.00	1.00	1.00
Traditional	4.22*	1.87*	1.20

* P < 0.05.

Quantitative analysis shows that health status, risk-taking and health-seeking behavior are related to socioeconomic status and masculine ideologies. Rural respondents are more likely to have experienced poor health, engage in risk-taking behaviors and less likely to seek for modern health care than their urban counterparts (Table 5). The influence of education is observed by the fact that educated respondents are less likely to have been sick, more likely to engage in risk-taking except those with tertiary level of education. The educated respondents showed more likelihood of health-seeking behavior than otherwise. They have knowledge and in most cases control enough financial resources to seek for health care. Logistic regression further shows that Igbo males who traditional masculine beliefs are more likely to have experienced poor health (OR=4.22) and engage in risky behavior (OR=1.87) than the non-traditional ones. Although non-significant, traditional oriented males are also more likely (OR=1.21) than their non-traditional counterparts to seek health care. This may be due to a misunderstanding of the question on health seeking behavior as respondents may have reported using health care services even if it is the traditional type.

Discussion and Conclusion

This study provides an important insight into how men's knowledge and attitudes toward gender ideologies and health interact. Qualitative data analysis shows that both young and adult men in the study associated masculinity with having many sexual partners, non-use of condoms during sexual act. It is also associated with independence, self-reliance, hard work, rationality, power and authority, aggressive, and tough. The analysis also shows that there are social and health costs attached to adherence to traditional gender

role ideologies. These costs arise from societal expectations of the Igbo male. Failure of the man to demonstrate proof of manhood reverberates in shame, ridicule and street jokes. Health consequences related to adhering to masculine ideology include STIs including HIV/AIDS, low sperm count, cancer, early ejaculation, wet dream, and herpes.

Health-seeking behavior may involve going to modern medical clinics, traditional herbal homes, seeking information from friends, chemists/pharmacy, using contraceptive when having sex. Obstacles to health seeking among Igbo men include financial constraints, pride, ego, fear of being stigmatized, religious beliefs, age, lack of information, familial and community obligations. Although stoicism is seen as a quality of manliness, most FGD participants claim that this is not a barrier to seeking health care.

Although Igbo men subscribe to cultural norms promoting masculinity, some argue that culture does not enforce obedience. They suggest that it will be out of fashion for men to adhere to the same set of values that their parents upheld. Traditional practices such as polygamy and multiple partnerships are today viewed as risky behaviors that cannot be upheld in contemporary society. They further pointed out that risk of infection; economic costs and general societal changes do not permit the continuation of such practices.

There seems to be an emerging general shift toward to non-traditional gender role beliefs and practices especially in the urban area and among those who have some level of education. Nonetheless, traditional masculinity is more common among rural men. Irrespective of masculine orientation, Igbo men seek health care when they are ill, but the timing of this is determined by a number of factors.

The findings from this study can guide programme designers and other personnel about how best to provide health care to males. Intervention and prevention programs can target cultural-specific beliefs and practices that place the man and his family at risk. Since men are seen as defenders of certain categories of women such as mothers, sisters and wives, programmers should emphasize this beneficial aspect of masculinity by encouraging males to discuss reproduction and safer sex with their partners. Focus on altering community norms of sexual behavior can lead to changes in deeply ingrained beliefs and

behaviors. Success of such approaches have been reported in diverse settings such as the U.S.A where sexist double standard declined, and in Uganda where HIV infection rate among pregnancy women fell from 21 percent in 1991 to 10 percent in 1998 (Halperin and Williams, 2001). Achieving this sort of change in masculinity and its associated behavior required the involvement of government, religious organizations, schools and the media.

Despite what we know about how masculinity can negatively impact men's health care, men's underutilization of services remains problematic. Broad-based strategies that take masculine ideologies into account are needed to increase men's utilization of health care services. This requires education for health care providers about masculine ideologies and individual men about the importance of health seeking and the detrimental effects of masculine role socialization. Research must focus on testing interventions designed to increase men's health seeking and participation in reproductive health services in order to determine the most effective strategies. Future research should also look into why men patronize commercial sex workers, even without the use of condoms, in this era of HIV/AIDS. Further research is needed into the cultural, social and economic factors associated with men's sexual and reproductive behaviors. Understanding men, their ideologies and helping them to overcome many socio-cultural barriers to help them play critical role in comprehensive reproductive health will be much gains to men, their partners and the society at large. Risk reduction and reproductive health programs addressing men's perception of risk, that emphasize the association between masculinity and health will help advance further the ICPD goal of gender equality, equity and reproductive health for all.

Acknowledgement:

Funding for this study was made possible by a gracious award from the Opportunities and Choices Reproductive Health Research, University of Southampton, Southampton S017 1BJ, United Kingdom. Appreciation is also sent to the Director of Takemi Program in International Health, Harvard School of Public Health, Boston, MA, USA, for providing logistics support to the first author to complete this study.

REFERENCES

- Achebe, Chinua (1958): *Things Fall Apart*. London: William Heinemann Ltd.
- Achufusi, G.I (1994): "Female individuality and assertiveness in the Novels of Ifeoma Okoye. In Helen Chukwuma (ed). *Feminism in African Literature*. Enugu, New Generation Books.
- AGI (2002): *In their own right: addressing the sexual and reproductive health needs of American men*. New York
- Ashraf, A., Tunion, C. et al (2000): "Knowledge of men about reproductive health issues and services in Bangladesh", *ICDDR, B Working Paper* No. 135.
- AVSC International/IPPF/WHR (1998): "Male participation in sexual and reproductive health: new paradigms: symposium Report", October 10-14, 1998. Mexico
- Bankole, A. and Singh, S (1998): "Couples fertility and contraceptive decision-making in developing countries: hearing the man's voice", *International Family Planning Perspectives* 24 (1).
- Barker, G (1999): "Listening to boys: some reflections on adolescent boys and gender equity", Paper presented at the AWID Conference Panel on Male Involvement in Sexual and Reproductive Health: Hindrance or Help to Gender Equity? November.
- Barker, G (1996): *The Misunderstood Gender: Male involvement in the Family and in Reproductive and Sexual Health in Latin America and the Caribbean*. Erickson Institute.
- Bayne-Smith, M. (1996): *Race, Gender and Health*. Sage Publications. Thousand Oaks, CA.
- Brod, H. (ed). 1987: *The making of masculinities: the new men's studies*. Boston: Allyn and Unwin.
- Canetto, S.S (1995): "Men who survive a suicidal act" in D.Sabo and D. Gordon, Eds. *Men's Health and Illness: Gender, Power and the Body*. Thousand Oaks, CA: Sage Publications, pp.46-67.
- Charmez , K. (1995): Identity dilemmas of chronically ill men. In D. Sabo and D.F. Gordon (Eds), *Men's health and illness: Gender, power and the body* (pp. 266-291). Thousand Oaks, CA: Sage.
- Chun, June (1990): *The Role of Women in Things Fall Apart*.
- Cleaver, F. (2000): Do men matter? New Horizons in Gender and Development. *Insights Development Research*. December 2000, 35-36.

Collumbien , M. and Hawkes, S. (2000): Missing men's messages: does the reproductive health approach respond to men's sexual health needs? *Culture, Health and Sexuality* 2(2): 135-150.

Courtenay, W.E. (2003): 'Key determinants of the health and well-being of men and boys', *International Journal of Men's Health*. www.findarticles.com/p/articles/mi accessed on 2005/03/11.

Courtenay, W.E. (2002): A global perspective on the field of men's health. *International Journal of Men's Health* 1: 1-13.

Courtenay, W.E. (2001): Men's Health: Ethnicity Matters. *Social Work Today*, 2(8): 20-22.

Courtenay, W.E. (2000): "Constructions of masculinity and their influence on men's well being: a theory of gender and health", *Social Science and Medicine* 50: 1385-1400.

----- (1998a): "Better to die than cry? A longitudinal and constructionist study of masculinity and the health risk behavior of young American men", *Dissertation abstracts*, University of California at Berkeley.

----- (1998b): "College men's health: an overview and a call to action", *Journal of American College Health* 46 (6): 279-290

Cummings, C. (1991): "AIDS education in California prisons", *California AIDS Clearing House Reviewer*, 3 (1): 1-3.

----- ; Lampone, D et al (1983): "What young men know about testicular cancer", *Preventive Medicine* 12 (2): 326-330.

Danforth, N and Green, C. (1997): Involving men in reproductive health: a review of USAID-funded activities. Arlington: Population Technical Assistance Project.

Davies, Jon; B.P. McCrae et al (2000): "Identifying Male College Students' Perceived Health Needs, Barriers to Seeking Help, and Recommendations to Help Men adopt healthier lifestyles", *Journal of American College Health*, Vol. 48: 259-267.

DeGregorio, E. and Carver, C.S. (1980): "Type A Behavior pattern, sex role orientation and psychological adjustment", *Journal or Personal Social Psychology* 39:286-293.

Dudgeon, Matthew R (2003): "Gender, masculinity and reproduction: anthropological perspectives", *International Journal of Men's Health*. Accessed on www.findarticles.com/p/articles/mi on 2005/03/11

Drennan, M. (1998): *Reproductive Health: New Perspectives on men's participation*. Population Reports Series J, Number 46, Baltimore, Johns Hopkins University School of Public Health, Population Information Program.

Eisler, R.M. (1995): The relationship between masculine gender roles stress and men's health risk: the validation of a construct. In R.F. Levant and W.S. Pollack (Eds), *A new psychology of men*. New York: Basic Books, pp 207-225.

Eschen, A, et al (1999): "Male sexuality in Colombia: Implications for new reproductive health services for men", Paper presented at the American Public Health Association Annual Meeting. November.

Ezeh, A.C. (1993): "The influence of spouses over each other's contraceptive attitudes in Ghana", *Studies in Family Planning*, 24 (3): 163-174

Farmer , P., Connors., M., and Simmons, J. (Eds). (1996): *Women, poverty and AIDS: Sex, drugs and structural violence*. Monroe, ME: Common Courage Press.

Feyisetan, B.J et al (1998): "Role of men in family planning in Imo State off Nigeria", *Population Research Fund*, NISER, Nigeria.

Foreman, M, (1999): AIDS and Men: Taking Risks or Taking Responsibility. London: Zed Books.

Gokova, J.K. (1998): "Challenging men to reject gender stereotypes" in *AIDS/STD Health Promotion Exchange*, Number 2.

Greene, M.E. and Biddlecom. A.E. (1997): "Absent and problematic men: Demographic accounts of male reproductive roles", *Policy Research Division, Working Paper*, No. 103, The Population Council, New York.

Halperin, D.T. and Williams , B (2001): This is no way to fight AIDS in Africa. *Washington Post*, August 26.

Harrison, I., Chin, I; Ficarroto (1992): "Warning: the male sex-role may be dangerous to your health", in Kimmel, M.S., Messner, M.A. (Eds), Men's Lives. 2nd Edition, pp 271-285.

Hawkes, S. (1998): "Why include men? Establishing sexual health clinics for men in rural Bangladesh", *Health Policy and Planning* 13 (2): 121-130.

Horwitz, A.V. and White, H.R. (1987): "Gender role orientations and styles of pathology among adolescents", *Journal of Health and Social Behavior*, 28 (2): 158-170.

Hull, Terence H. (2000): *Engaging and Serving men in the Indonesian reproductive health program: Issues and Obstacles*. Paper presented at the PAA Annual Conference

Inhorn, M.C (2002): Sexuality, Masculinity and Infertility in Egypt: Potent troubles in the marital and medical encounters. *Journal of Men's Studies* 10: 343-359

Inhorn, M.C. (2003): "The worms are weak": Male infertility and patriarchal paradoxes in Egypt. *Men and Masculinities* 5(3):236-256.

IPPF/RHO/AVSC (1998): Men as Partners Initiative: Summary Report of Literature Review and Case Studies, New York.

Isiugo-abanihe, U (2003): Male role and responsibility in fertility and reproductive health in Nigeria. CEPAED, Ababa Press Ltd, Ibadan , Nigeria.

Johns Hopkins University Center for Communication Programs (1999): Helping Involve Men (HIM) CD-Rom.

Kandrack, M., Curank, K.R. and Segall, CA (1991): "Gender differences in health-related behaviour: some unanswered questions", *Social Science and Medicine*, 32 (5): 579-90.

Kaufman, M (1994): "Men, feminism and men's contradictory experience of power" in Brod, H; M. Kaufman (Eds). *Theorizing Masculinities*. Sage Publications, Thousand Oaks, CA, pp.142-163.

Keijizer, B (1995): "Masculinity as a Risk Factor", Seminar on Fertility and the Male Life Cycle in the Era of Fertility Decline, IUSSP, and Zacatecas

Kimmel, M.S. (1986): "Introduction toward Men's Studies". *American Behavioral Scientist* 29 (5): 517-529.

Kuteyi, Modupe (2001): "Women's perception of reproductive morbidity in Osun State, Nigeria", forthcoming in *African Journal of Women's Studies*..

Landry, David (1997): "Data needs regarding male reproductive health and services", prepared for NICHD Workshop "Improving Data on Male Fertility and Family Formation" at the Urban Institute, Washington DC, January 16-17.

Levine, F.M. and DeSimone, L.L. (1991): The effects of experimenter gender on pain report in male and female patients. *Pain* 44: 69-72

Lorber , J (1997): Gender and the social construction of illness. Thousand Oaks, CA: Sage

Mahalik, J.R., Locke, B. et al (2003): Development of the Conformity to Masculine Norms Inventory. *Psychology of Men and Masculinity* 4: 3-25

Mansfield, A.K (2003): “Why won’t we go to the doctor?”: The psychology of men’s help-seeking. *International Journal of Men’s Health*. www.findarticles.com accessed on 2005/03/11.

Maskowski, C. (1999): The role of sex and gender in pain perception and responses to treatment. In R.J. Gatchel and D.C. Turk (Eds), *Psychological factors in pain: Critical perspectives* (pp. 401-411). New York: The Guilford Press.

Mbizvo, M.T and Basset, M.T. (1996): “Reproductive health and AIDS Prevention in sub-Saharan Africa: the case for increased male participation”, *Health Policy and Planning*, March, 11 (1): 84-92.

Moynihan , C. (1998): Theories of Masculinity. *British Medical Journal* 317: 1072-1075.

Mundigo, A.I. (1998): “Reconceptualising the role of men in the post-Cairo era”, IUSSP Seminar on Men, Family Formation and Reproduction. Buenos-Aires, 13-14 May

----- (1995): “Men’s roles, sexuality and reproductive health”, *International Lecture Series on Population Issues*, The John D and C.T. MacArthur Foundation, Chicago.

Nix, J and J.M. Lohr (1981): “Relationship between sex, sex role characteristics and coronary-prone behavior in college students”. *Psychological Report* 48: 739-744.

Odimegwu, C, Adewuyi, A.A et al (2002): “Men’s role in emergency obstetric care in Nigeria”, submitted to *International Family Planning Perspectives*, New York.

Odimegwu, C., (2002): “Prevalence, Patterns and Predictors of Gender-based violence in Benue State, Nigeria”, submitted to *Violence Against Women Journal*, Philadelphia.

Okemgbo, C. (2001): “Gender role ideology and prevalence of gender-based violence in South East Nigeria”, forthcoming in *Journal of Sociological Studies*.

Omideyi, A.K., C.Odimegwu and M.Raimi (1999): “Couples’ fertility decision-making in Nigerian”, Research Report Submitted to Population Research Fund/Nigerian Institute for Economics and Social Research, Ibadan, Nigeria.

Ozumba , G.O (2005): Gender-sensitivity in Igbo culture: A philosophical Re-appraisal. *Quodlibet Journal* , 7 (2): 1-7. www.quodlibet.net accessed on 2005/06/14

Puntillo, K. and Weiss, S.J (1994): Pain: Its mediators and associated morbidity in critically ill cardiovascular surgical patients. *Nursing Research* 43: 31-36

Patrick, K.M., Covin, J.R., Fulop, M. et al (1997): Health risk behaviors among California College Students. *Journal of American College Health* 45 (6): 265-272.

Powell-Griner, E., Anderson, J.E., Murphy, W. (1997): State- and Sex-specific prevalence of selected characteristics – behavioral risk factor surveillance system. 1994 and 1995 Morbidity and Mortality Weekly Report, Centers for Disease Control, *Surveillance Summaries*, 46 (3): 1-31.

Pyke, K.D. (1996): “Class-based masculinities: the interdependence of gender, class and interpersonal power”, *Gender and Society* 10:527-549

RHO (1999): Men and Reproductive Health: Bibliography. <http://www.rho.org>

Ratner, P.A., Bottorf, J.L et al (1994): “The interaction effects of gender within the health promotion model”, *Research in Nursing and Health* 17:341-350.

Sabo, D. and Gordon, D.F (eds) (1995): Men’s Health and Illness: Gender, Power and the Body. Sage Publications, Thousand Oaks, CA.

Sargent, C.F. and Bretell, C. (1996): (Eds): Gender and Health: An International perspective. Upper Saddle River, NJ: Prentice Hall.

Sharpe, M.J., Heppner, P.P. and Dixon, W.A. (1995): Gender role conflict, instrumentality, expressiveness, and well-being in adult men. *Sex Roles*, 33(1/2), 1-18.

SSRHN (1999): Male Responsibility in Reproductive Health: the construction of manhood in Nigeria. Phase 1: Ibadan, Nigeria.

Smyth, J.M (1998): Written emotional expression: effect sizes, outcome types and moderating variables. *Journal of Consulting and Clinical Psychology* 66: 174-184

Stillion, J. (1995): “Premature death among males” in D. Sabo and DF Gordon, op.cit. pp 46-69.

Uchendu, V.C (1968): The Igbo of South Eastern Nigeria. New York: Holt

Unruh , A.M, Richtie, J and Merskey, H (1999): Does gender affect appraisal of pain and pain coping strategies? *Clinical Journal of Pain* 15, 413-427.

UN (1994): Report of the International Conference on Population and Development, Cairo, 5-13 September, New York.

UN (1995): The Beijing Declaration and Platform for Action. New York: UN

UNAIDS (2000): “Men make a difference: objectives and ideas for action”, UNAIDS: Geneva, Switzerland.

----- (2001): Working with men for HIV Prevention and Care. UNAIDS: Geneva, Switzerland.

-----/The Panos Institute (2001): Young men and HIV: Culture, Poverty and Sexual Risk.

UNDP (2000): Men, Masculinities and Development: Broadening our work towards gender equality.

UNFPA (2001): Enlisting the support of Men. www.unfpa.org

UNFPA (2000): Partners for Change: Enlisting Men in HIV/AIDS Prevention. UNFPA: New York.

UNFPA (1999a): “Male involvement in reproductive health, including family and sexual health”, *UNFPA Technical Report*, No. 28, New York.

UNFPA (1995b): Male involvement in Reproductive Health: Partners for Women’s empowerment, New York.

UNICEF (1995): Men in Families: report of a consultation on the role of males and fathers in achieving gender equality. New York

USAID (2001): Involving men in Sexual and Reproductive Health. USAID: Washington, USA.

Verma, R.K., Sharma, S. et al (2001): “Beliefs concerning sexual health problems and treatment-seeking among men in an Indian slum community”, Paper presented at the 3rd IASSCS, 1-3 October, 2001, Melbourne, Australia.

Ward, V.M., Bertrand, J.T and Puac, F.(1992): Exploring sociocultural barriers to family planning among Mayans in Guatemala. *International Family Planning Perspectives* 18(2): 59-65

Waldron, I. (1983): “Sex differences in illness incidence, prognosis and mortality”, *Social Science and Medicine*, 17: 1107-1123

Walker, S.N, Volkan, K et al (1988): “Health promoting lifestyles of older adults: comparisons with young and middle-aged adults, correlates and patterns”, *Advances in Nursing Science* 11, 76-90.

WHO (2000): “What about boys? A literature review on the health and development of adolescent boys”. Geneva, Switzerland.

-----/UNAIDS (2001): The health and development of African Male adolescents and young men. Geneva, Switzerland.

