Chapter-V

INITIATIVES FOR MEN'S PARTICIPATION IN REPRODUCTIVE HEALTH IN INDIA

In India, the study of male's role in family planning is still a neglected area. However, historically, in the Indian family planning program, the contraceptive use pattern has undergone major changes during the last 30 years. From 1960 to 1977, males were the main acceptors of Family Planning (Vasectomy and Condom) and their proportion was always more than 50 per cent of the total family planning acceptors. However, as a consequence of the excesses during the emergency for promoting vasectomy, the program received a major set back. With the introduction of new technology like mini-lap and laparoscopic sterilisation slowly the program orientation shifted towards women.

India’s efforts to address the problems of maternal and child health, during the last half century have been a series of exercises in semantics, frequently changing the name of the programme, the latest being the ‘Reproductive and Child Health approach’. Strategic planning for an improved health scenario has been noticeably missing  

The planners' preoccupation of meeting the demographic goals of reducing fertility is evident from the fact that the family planning component has largely overshadowed the other aspects of the programme. Moreover, there has been a “genderisation of family planning responsibilities”. In the sixties, 11 per cent of the sterilisations were tubectomies, in 1993, they accounted for 96 per cent of the same.

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Government sponsored programmes have conveniently overlooked the fact that procreation is the result of an equal and active role of both the partners. Encouraging male responsibility has largely remained only an “idea”. Unfortunately, the women have been at the receiving end of all experimentation of reducing fertility through contraception or other methods.

There has been a scant involvement of men in reproductive health programmes, though the National Population Policy 2000 calls for an increased participation of men. The male role has been gradually declining over the years largely due to the entire focus of these programmes being on women. The male belief that childcare is the exclusive domain of women or regarding STDs as women’s diseases or as shameful diseases have discouraged men participation. This has been further compounded by lack of acceptance of health care providers of the opposite sex and needless to say that the health care work force is female intensive.

The attitude of health care providers can also be a barrier. Men made to feel unwelcome, there is lack of discretion/confidentiality and rules of counselling are misapplied. Insufficient quantity of appropriate and high quality IEC materials and low level of knowledge among men concerning reproductive health issues and availability of services are some of the key issues which need to be addressed if men’s involvement is to be worthwhile.²

The relationship between men’s self-interest and reproductive health has largely been ignored. Men feel that reproductive health does not concern them and have not yet

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realized its advantages. High cost of services, geographical distance and cultural barriers to accessibility and availability of reproductive health also come into play.

The male perspective has also been largely ignored by researchers. Husbands were interviewed in only 7 per cent of world fertility surveys. Again they were interviewed in only 33 per cent of Demographic and Health Surveys in progress or completed till 1993. A 40 year analysis of POPLINE graph has led experts to conclude that men are neglected in research on fertility and family planning. Gender inequality is the root cause of men being invisible from the reproductive health scenario, which is further compounded by their palpable sense of masculinity.³

In India, gender inequalities favour men and sexual and reproductive health decisions are usually made by them. Therefore, there is a growing realisation that unless men are reached, the Reproductive and Child Health Programme, including family welfare efforts, will have limited impact. Direct evidence on the use of male methods is scarce as men have been excluded from most of the national surveys, and small-scale studies exploring the contraceptive behaviour of men are limited.

Data from NFHS–2, based on the responses of currently married women, show that one in ten currently married “couples” were using male/couple-dependent contraceptive methods (condoms, vasectomy, withdrawal and periodic abstinence) in 1998–99, which translates into 21 per cent of total current contraceptive prevalence.

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During the six-year period between NFHS–1 and NFHS–2, the use of male/couple-dependent methods remained the same. At the state level, all the southern states recorded a decline, ranging from 21 per cent to 46 per cent in the proportion of currently married couples using male/couple-dependent methods during the 1990s. Among the Changing family planning scenario in India: An overview of recent evidence four major northern states, while Madhya Pradesh and Bihar recorded a decline, the proportion of couples using male methods increased in Uttar Pradesh and Rajasthan. Data specifically on the use of condoms reveal that only a small minority (3.1%) of currently married couples were using condoms. Despite the introduction of “no-scalpel” vasectomy and campaigns to promote male involvement in family planning and reproductive health, the acceptance of vasectomy remained negligible 2 per cent of currently married couples nationally.\(^4\)

Equality between men and women is a matter for society at large, but it begins in the family. Understanding gender discrimination means understanding opportunities and constraints as they affect men as well as women. Men’s attitudes and behaviours are strongly influenced by societal expectations about what it means to be a man. In particular, the assumption that contraception, pregnancy, childbirth and prevention of sexually transmitted diseases are exclusively women’s concerns reinforces men’s lack of involvement in safeguarding reproductive health - both their own and that of their partners. Their masculine image deters them from getting involved in these feminine activities.\(^5\)


The overtly “gynocentric” approach of the policy makers to reproductive health issues further discourages male involvement. Men, by and large remain invisible from the reproductive health scene. Men can support reproductive and sexual health since they are more likely than women to be literate and to have better access to information, and are often in a better position than women to inform themselves about reproductive health. Dr. Leela Visaria, active in reproductive health policy in India, concludes that “research needs to go beyond estimations of incidence and prevalence and probe into power relations between partners”, including the negotiation and decision-making process. Various micro level efforts have been made to increase men’s interest in their own and their partners’ reproductive health. Community-based approaches have addressed a range of concerns. Programmes have worked with groups of men, creating opportunities for easier communication. Traditional authorities have been enlisted to motivate men. Better ways for men to find accurate information have been created. Interestingly many of the lessons learnt have been from India.\(^6\)

Men’s illnesses were immediately apparent because of their impact on wages; wives' illnesses became known only when they told their husbands or when the household routine was disturbed; women were more likely to conceal their health needs because of the expenses. Efforts to involve men in reproductive health must include education about gender relations and shared opportunities.

The NGO Social Action for Rural and Tribal Inhabitants of India (SARTHI) has worked in traditional settings to improve women’s status and reproductive health. The group’s initial work on women’s health was found to improve men’s awareness and sensitivity to gender issues. Contrary to expectations, men did not feel threatened by

\(^6\) *Ibid.*
women’s meetings and even volunteered to take on domestic chores so that their wives could participate. SARTHI then began to include men of all ages in the programme and began training men as health workers in a new community health programme serving men and children. After several years, SARTHI recognised that work to empower women needs to be accompanied by action to sensitisate men about gender relations, to free them from patriarchal definitions of masculinity.7

Personal transformation is necessary before male health workers can become good community role models. Another NGO, the Centre for Health Education, Training and Nutrition Awareness (CHETNA), started working to involve men in its reproductive health programmes in the early 1990s, when it realised the extent of husbands' domination and neglect of their wives and the effect this had on women’s health; women said they were not even free to decide how much food they ate.8

The men discuss issues such as alcoholism, smoking, malnutrition, family planning and women’s literacy. Mothers-in-law in India exercise great influence in the household; the project encourages them to promote proper nutrition and childcare and to motivate their sons to treat their wives better, because “only a healthy and happy mother produces a healthy child”. Two local health centres offer services for adolescents and a letterbox has been set up for their questions about sex and reproduction. There has been a definite change in young peoples’ awareness and perspectives in the five years since the project began. Boys now ask fewer questions about girls’ virginity, and more about the

7 Ibid.
8 Ibid.
involvement of men in raising children. Questions about STDs, AIDS, contraception and safe sex are also frequently asked.\footnote{Ibid.}

Boys expressed increasing concern about girls' problems and are now more likely to ask about menstruation. More young people now view sex as not merely about pleasure or procreation, but as a part of “expressing and sharing love”. More girls want to share household chores and child-rearing with their future partners.

In FWES project villages, girls’ enrolment in schools has increased and sex ratios for new-borns have not changed, unlike neighbouring villages, where girls’ enrolment has decreased and female births have declined sharply. However, the clubs have not caught on in other villages and involvement has reached a plateau. In urban Delhi a project, Men in Maternity is similarly encouraging men's participation. Save the Children UK has supported the making of four films in Bangladesh, India, Nepal and Pakistan; the project “Let’s Talk Men” uses the films to build awareness on gender relations, so boys will adopt more responsible attitudes about women and sexual relations.\footnote{Ibid.}

Men and women are mutually indispensable partners in sexual and reproductive relationships, marriage and family building. The movement to involve men in reproductive health has many names, including men's participation, men's responsibility, male motivation, male involvement, men as partners, and men and reproductive health. As yet, there is no consensus about which term best describes the new perspective on men, what these terms mean, and how men can best be involved in reproductive health activities.

\footnote{Ibid.}
\footnote{Ibid.}
The term “men’s participation” describes men's active, positive involvement in achieving good reproductive health. AVSCs outlined men as partners’ initiative in exploring the meaning of word “Partner”. Participants agreed that in the context of reproductive health, the term must take into account differences stemming from socio-economic and cultural factors. Whatever the term used, the purpose is to describe a complex process of social and behavioural change that is needed for men to play more responsible roles in reproductive health. Men's participation can be seen as a mean to an end, rather than as a goal in itself.\textsuperscript{11}

The goal is good reproductive health for all, and men can help in many different ways to make that a reality. A growing number of family planning and other reproductive health care programs and providers are seeing that men deserve more attention - for their own sake, for women's sake, and for the health of their families and communities. From this new perspective, men are potential partners and advocate for good reproductive health rather than bystanders, barriers, or adversaries.

This new attention contrasts with several decades of neglect that began in the 1960s after the development of modern contraceptive methods for women.\textsuperscript{12}

Due to the sensitivity of the topic, little is known about the sexual activity of unmarried adolescent males or about their knowledge and attitudes toward sexuality and reproductive health. Planning programs and other reproductive health care providers were accustomed to paying little attention to men except for the diagnosis and treatment


\textsuperscript{12} Ibid.
of sexually transmitted diseases (STDs). Now, reproductive health programs are seeking better ways to understand men, to communicate with them, to engage them, and to help them take better care of themselves and their partners.

According to Khan, very little however, is known about how to enhance male involvement in RCH. Given the patriarchal social structure of South Asian countries, bringing about changes, which strive to enhance male involvement, and the gender equity this implies, is not easy. Against this backdrop, it is interesting to look at how the Ministry of Health and Family Planning, Government of India (MOH&FP), which is committed to implementing ICPD Programme of Action, is addressing the issues related to motherhood services. Needs-based, client-oriented, demand-driven, improving quality of services in RCH.¹³

The need for addressing gender disparities and male involvement was mentioned in the 9th Five Year Plan that too only in two lines. The Population Policy, which was recently approved also briefly, discusses this issue. In the absence of a clear policy directive and a monitoring system with built-in indicators to measure achievements of the programme in enhancing male involvement in reproductive health programmes, it is difficult to understand how the Family Welfare Programme could address this issue, which is not only new for programme personnel, but also difficult to implement. In-depth interviews with programme managers at different levels clearly illustrate this dilemma. The top programme managers, both at the state and central levels, have good comprehension of the issues involved.¹⁴

They appreciate and agree that male participation in the provision of reproductive health services is critical for the success of the RCH programme, but they are not sure how to do this. Lack of innovative and replicable models was mentioned several times during the interviews. Other important hurdles which they see are the lack of intersectoral coordination and the need for broad-based social change addressing issues related to gender equity.

In this regard, UNESCAP (2003) organised a training in New Delhi which aimed to highlight ideas, concepts, polices, approaches and strategies for a greater involvement of men to eliminate gender violence with men partnership.\(^{15}\)

Some NGOs have experimented with one or the other intervention to involve men in safe motherhood and reproductive health. These NGOs including Family Planning Association of India (FPAI), Social Education for Women's Awareness (SEWA), Child in Need Institute (CINI), Deepak Foundation, Vellore MC, the Community Aid and Sponsorship Programme Plan (CASP), Adithi, Centre for Health Education, Training and Nutritional Awareness (CHETNA), Talking About Reproductive and Sexual Health Issues (TARSHI) and Family Welfare and Education Services (FWES).

The review shows that all these projects were initially planned for addressing only women's reproductive needs. Male involvement was an afterthought. In some cases, a male component was included in the project on the demand of women themselves who felt that unless their husbands and other male members are also educated about reproductive health issues and involved in services provision; they could not get the

\(^{14}\) Ibid.  
\(^{15}\) Ibid.
greatest benefit from these programmes. This led to the addition of a male component to the programme.\textsuperscript{16}

The interventions to involve men varied in nature, depending on the thrust of the NGO’s reproductive health projects. It included male workers, male peer educators, husbands of pregnant women, newly married couples, educational camps, question boxes in schools and male clubs. As most of the NGO’s projects were planned as service delivery projects, the interventions were rarely properly designed, implemented or evaluated.

As a result, assessing the precise impact of the interventions is difficult. However, they certainly provide indications as to which interventions are more promising than others. Interventions or programmes which appeared more promising in changing attitudes as well as behaviour include making use of male health workers as well as women health workers; younger male providers are more effective and better change agents; using peer group educators; and contact with newly married couples.\textsuperscript{17}

Interventions that appeared to be helpful in dissemination of knowledge include: a hotline, community involvement through meetings, camps, question boxes in schools and special educational camps or exhibits for men. Interventions that are either not effective or achieve unclear results include: clubs (men’s club, adolescents’ club), male-clinics and condom vending machines. In the absence of a well-designed study, the conclusion arrived at above could be questioned, but at least these NGOs’ initiatives give some useful leads as to where to begin.

\textsuperscript{16} Ibid.
\textsuperscript{17} Ibid.
It is suggested that some of the more promising interventions should be properly designed, implemented and evaluated before planning up-scaling. The study thus reveals that a serious effort to involve men in reproductive health has yet to be made in India. While the NGOs have taken some initiative and could provide some leads as to possible interventions, ultimately it is focused policy and programmes on the part of government which will make a difference.\textsuperscript{18}

At present, the Government has not crystallised any definitive policy or programme which could help in the involvement of men. In South Asian countries, where men are equally subject to strong social constructs which discourage them from straying from socially ascribed 'gender roles', involving them in safe motherhood or promoting gender equality demands inter sectoral coordination between various ministries such as Education, Women and Child Welfare, Health and Family Planning. In the absence of a collective initiative of this kind, efforts for male involvement within the Ministry of Health and Family Planning are reduced to a few initiatives to promote vasectomy and the condom - male involvement in reproductive health remains a remote goal. Some family planning programs have avoided men because they assume that men are indifferent or even opposed to family planning.\textsuperscript{19}

Indeed, men are a diverse group of individuals. They reflect the spectrum of humanity, from kind and caring to abusive and dangerous. While some men do prevent women from using family planning, spread STDs to their female partners, or act in other harmful ways, most men do not. It is important that health programs abandon stereotypes

\textsuperscript{18} Ibid.
\textsuperscript{19} Ibid.
of men and learn more about their concerns and needs, especially when designing. In India, men are recognised as the head of the family and they take most of the family decisions.

As a result, attitudes regarding contraception, the desired number of children and the actual use of contraceptives are influenced greatly by the husbands. Therefore, governments should incorporate male providers, namely social workers and clinicians to provide information, education and communication, counselling and reproductive health services to men, in order to enhance the participation of men in the well fare of their families. Men’s demand for methods to stop or limit birth was low, since they desired large families. Hence it is essential to create interest and cultivate initiation among men regarding their role in family welfare.\textsuperscript{20}

Providing detailed scientific information through interpersonal relations, audio visual and folk media relating to contraceptive methods, strong motivation to limit fertility, the acceptance of men’s role and responsibility in family building as responsible fatherhood may increase the involvement of individuals in family welfare and thereby decrease the strong son preference. Hawkes and Collumbien argued that the sexual health of men’s cannot adequately addressed unless men’s beliefs about their bodies, men’s health priorities, men’s sexual concerns are evaluated, interpreted and acted upon. Services which do not correspond to men’s own perceived service needs are unlikely to attract men as clients, and thus remove many of the opportunities for male involvement in other reproductive and sexual health prevention and care.\textsuperscript{21}

\textsuperscript{20} Ibid.
\textsuperscript{21} Ibid.
Boys and men have been left out in our efforts to improve sexual and reproductive health. A national survey of family planning clinics by the Family Planning Association showed that young men have much less access to sexual health services than women. Few studies have addressed young men's involvement in decisions about termination of pregnancy, though one qualitative study of the attitudes of teenage boys showed a desire to be involved and to receive emotional and social support. Little research has been done into the possible emotional squealer of termination decisions for men. Three broad approaches exist to improving men’s participation in activities concerning sexual health, though there is a frustrating lack of evidence to show that these initiatives will have social or clinical impact. Firstly, experts in sex education argue that we should start with what boys want, rather than what adults think they need. This means that boys should participate in developing education programmes, influencing the content, delivery, and setting of their sex education.22

This approach was used by the Sex Education Forum and the Family Planning Association in developing practical guides to work with young men. Secondly, we should be more honest to young men about the barriers in using condoms and practising safe sex, including embarrassment, fear of failure, and loss of sensitivity. A basic concept is to understand the anxieties of young men starting their sexual “careers.” Initial difficulty in using a condom may influence a young man's attitudes to condoms forever. Practising condom use during masturbation may alleviate anxiety, and one author has argued that healthcare systems should pay for condoms for such practice. In discussions with young
men about sex, we should include notions of pleasure and not just prevention, for many pleasurable activities are also safe ones. Increasing the range of contraceptive choices for men will be empowering for both men and women, and a recent international survey found that most men would consider taking a “male pill.”

We need to make sexual health services more accessible to boys and men. Motivating men to take a more active interest in sexual and reproductive health could be rewarding for us all. Encouraging young men to avoid risky sexual behaviours can result in better reproductive health for everyone. Services which do not correspond to men’s own perceived service needs are unlikely to attract men as clients, and thus remove many of the opportunities for male involvement in other reproductive and sexual health prevention and care. Boys and men have been left out in our efforts to improve sexual and reproductive health.

Objections were raised to focusing on men's needs, including the concern that this may jeopardise reproductive health services for women and that men already have too much power over decisions affecting women's fertility and sexual health. Nevertheless, increasing evidence exists that ignoring the sex education and sexual health needs of young men has important and wider social and health consequences. There is widespread research and media interest in the idea of male adolescence as a negative and chaotic experience and a poor preparation for adulthood.

22 Ibid.
23 Ibid.
24 Ibid., pp. 13-19.
Finally, we need to make sexual health services more accessible to boys and men. We should consult them locally to assess their needs, advertise services in an informal and attractive way, broaden the settings of service provision, and provide for specific groups such as young gay men and men from ethnic minorities. Motivating men to take a more active interest in sexual and reproductive health could be rewarding for us all.

There is no universally accepted understanding of what it means to include men; rather, a variety of interpretations exist of the concepts of male involvement and male responsibility. Men are involved in reproductive health through their multiple roles as sexual partners, husbands, fathers, family and household members, community leaders and gatekeepers to health information and services.\textsuperscript{25}

Though Government of India has endorsed the ICPD agenda and some attempt has been made to carry forward this agenda. It is only since 2000, two important documents, National Population Policy (2000) and Tenth Five Year Plan (2002-07) have specifically mentioned importance of male involvement in planned parenthood, promotion of male contraceptives and control of STI/RTI. However, male involvement in reproductive health is still a new concept for the planners.\textsuperscript{26}

\textsuperscript{25}Ibid.

IMPLEMENTATION STRATEGIES OF MEN'S INVOLVEMENT IN REPRODUCTIVE HEALTH

Table 5.1

Key steps to implementing projects that Involve men in Reproductive Health through Maternal and Child Health

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<tr>
<th>IMPLEMENTATION ACTIONS</th>
<th>IMPLEMENTATION ACTIVITIES</th>
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<tr>
<td>Assess infrastructure of clinics and maternity wards in hospitals and their accessibility to men</td>
<td>Conduct a facility-based analysis to understand how clinic functions, services offered, patient flow, and time spent with each patient. Consider if privacy and confidentiality is assured (e.g., rooms with closed doors, curtains between beds). Conduct focus groups with providers to assess their attitudes about treating men and couples. Assess if clinics have waiting rooms and if so. Are they gender neutral and male-friendly? Review guidelines and protocols, available equipment, drugs and commodities that provide quality MCH care.</td>
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<tr>
<td>Assess attitudes among women and men in the community</td>
<td>Conduct focus group discussions with women, or surveys to find out if they want to involve their partners in FP, MCH, HIV/AIDS prevention, and/or addressing issues of Violence. Assure women that they decide as to whether or not to involve their partner. They must give consent for him to be involved. Conduct separate focus groups or surveys with men to find out if they want to be involved.</td>
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<tr>
<td>Advocate and buy in activities with decision makers and local leaders</td>
<td>Host meetings with department of health Officials at national, provincial, and regional level to inform, promote, and encourage buy-in to male involvement programs. Where appropriate, include traditional and local leaders or have separate meetings with them. Use these meetings to get feedback and agree on windows of opportunity for initiating male involvement programs.</td>
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<tr>
<td>Promote and advertise male involvement Program</td>
<td>Advertise that clinics welcome men. Dispel the notion that clinics are for women only. Partner with community leaders, media organisations, churches, and community centres to let people know that men are welcome at clinics.</td>
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<tr>
<td>Develop plans of actions</td>
<td>Action plans should consider how involving men affects every aspect of service delivery (e.g., scheduling, time spent per client, patient flow, tracking and monitoring client visits, costs, décor and upkeep of waiting rooms and rest rooms). Action plans should include adjustments to infrastructure to assure privacy and confidentiality (e.g., rooms with doors, curtains between beds).</td>
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<tr>
<td>Adjust or develop monitoring tools and management information systems to track services provided to men and women</td>
<td>Establish systems that disaggregate data by gender and services provision (e.g., number of counselling sessions provided and issues addressed, number of men and women that visit the clinic and services they receive).</td>
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<tr>
<td>Training</td>
<td>Train all staff from doctor to maintenance staff about working with men; provide on-going technician training to nurses and counsellors who will be working with men.</td>
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<tr>
<td>Develop and disseminate training materials for in-service training and IEC materials geared for couples</td>
<td>This may require setting up a technical working group to develop materials or outsourcing this activity to an experienced NGO or governmental department. Discuss and distribute IEC materials to women and men in couple counselling sessions. Encourage couples to tell their friends that clinics are not for women only but also welcome men.</td>
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<tr>
<td>Introduce couple counselling</td>
<td>Offer couple counselling as an alternative to individual counselling based on women’s consent. Consider flexible hours for couple counselling taking into account men’s work schedule. Consider group counselling as an alternative to couple counselling to facilitate scheduling.</td>
</tr>
<tr>
<td>Evaluate project</td>
<td>Use monitoring tools, interviews, and focus group discussions with providers, clients, and community leaders.</td>
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The seven projects presented herein illustrate opportunities to include men in maternal and child health programming.27

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Involving Men in Antenatal and Postnatal Care: The Men in Maternity Project in South Africa. Despite such obstacles as staff reluctance to include men in maternal health services and an infrastructure that was unwelcoming to men because of lack of privacy and inflexible clinic hours, this project found that men are interested and willing to be involved and women want such involvement.

Successfully Involving Men in Maternity Care: The Men in Maternity Project in India. This project successfully overcame health care workers’ discomfort in doing demonstrations of proper condom use by having male doctors initiate such demonstrations.

Involving Husbands in Safe Motherhood: The Suami Siaga (“Alert Husband”) Campaign in Indonesia. The project aims to involve men in MCH through a mass media campaign.

Supporting Married Adolescent Girls: Encouraging Positive Partner Involvement (India). This project sought to better understand the social context and health seeking behaviour of young couples experiencing the first birth.\(^{28}\)

Promotion of Male Involvement in Adolescent Married Women’s Reproductive Health through Reproductive Health Education in Rural Area in Maharashtra, India, a community-based intervention trained peer educators to impart knowledge about reproductive and sexual anatomy and physiology, menstruation, pregnancy and delivery, contraception, infertility, RTIs and STIs, HIV and AIDS.\(^{29}\)

\(^{28}\) *Ibid.*

\(^{29}\) *Ibid.*
Caring Men? Husbands' Involvement in Maternal Care among Young Couples in Rural India: This operations research project inquired about what men with young wives know about maternal care. It also asked: “How does the socio-cultural context influence husbands’ participation in maternal care among young couples? What other factors are associated with husbands’ participation in maternal care for young wives?”

The lessons learned pertain to adjusting institutional structures to welcome men and women and to outreach and dissemination strategies that target men.

- Public services have to adjust their institutional structures to accommodate working men and women and provide career opportunities to health care professionals interested in involving men in MCH. Structural adjustments should consider revisiting rotations, scheduling flexible hours for couple counselling, strengthening monitoring, and supportive supervision. Hospital management and staff should be involved at the outset of couple-service interventions to accommodate couples that wish to be together during delivery.\(^{30}\)

- Outreach to communities needs strengthening to inform larger numbers of men that they are welcome to participate in their partner’s maternity care, based on their partners consent, and to disseminate information targeted at sub-groups of men and women (e.g., adolescents, at risk, illiterate, employed, unemployed, urban, rural).

- Health care providers need additional training on how to serve couples and how to conduct couple counselling.

\(^{30}\) \textit{Ibid.}\
New strategies need to be designed to address remaining challenges in HIV/VCT (Voluntary Counselling and Testing) and integration of other services into Maternal services.\footnote{Ibid., p. 6.}

**Program Lessons**

Nine major lessons learned from research and program experience can help to increase men's participation:

- **Reach Male Audiences with Appropriate Messages**
  - Lesson 1. Build on men's approval of family planning.
  - Lesson 2. Use the mass media to communicate with men.
  - Lesson 3. Reach out to young and unmarried men.

- **Use Communication to Promote Behaviour Change**
  - Lesson 4. Understand the influence of gender.
  - Lesson 5. Encourage couple communication.

- **Offer Information and Services that men Want**
  - Lesson 9. Offer men a range of health services.\footnote{Ibid.}

**New methods:** One aspect of efforts to increase men's participation is the continuing quest for new contraceptive methods for men. It is argued that men do not have enough methods to choose from; if there were more choices, more men would use family planning. The search for safe, acceptable male hormonal methods has continued for more than 20 years. Research in recent years has produced some promising results with various hormonal implants and injections as well as possible vaccines. Clinical trials of one new

\footnote{Ibid., p. 6.}
hormonal method took place recently in 15 centres in nine countries. It will be at least another decade, however, before a hormonal method for men could become available. The pace of development currently is slow for several reasons. Men's fertility is more difficult to control than women's because men are fertile all the time. Also, major pharmaceutical companies have been reluctant to invest in research, development, and marketing of new male methods.33

**New models:** Proven men's programs, such as condom social marketing, workplace programs, and male clinics, serve men in many countries. Providers seeking to go beyond such programs and to encourage men to adopt more positive roles in reproductive health need new program models. New examples of best practices can help translate the new perspective into action.

**Strengthening Men's Participation activities:** To improve women's and men's reproductive health, policies and programs must:

- Encourage men to take more responsibility for their sexual behaviour;
- Increase men's access to reproductive health information and services;
- Help men to communicate with their partners and make contraceptive choices together; and
- Address the reproductive health care needs of couples34

Increasingly, recognition is growing on a global scale that the involvement of men in reproductive health policy and service delivery offers both men and women important benefits. Cambodia has acknowledged these benefits and is one of the first nations to

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promote male involvement at the policy and service implementation levels. With little opposition to involving men in reproductive healthcare, Cambodia evidences clear support for male involvement in RH.\textsuperscript{35}

The national agenda recognises the importance of gender issues, but usually only with respect to promoting the rights and situation of women. There is some concern, however, that a narrow focus on gender could impede efforts to promote and expand services for men. Several government policies and strategies mention men, and others offer strong opportunities for male involvement. The most important of these opportunities is the new five-year National Reproductive Health Strategic Plan, scheduled for a 2006 launch and offers following recommendations.

A set of guidelines to mainstream male involvement need to be developed and distributed.

- Agencies interested in implementing male involvement in reproductive health must plan for a long term commitment.
- Campaigns need to be implemented that educate seemingly “low-risk” social and demographic groups.
- Current education campaigns need to be reviewed in the context of male involvement and should not, for example, reinforce gender inequities or the notion that condom use is restricted only to high-risk situations.\textsuperscript{36}
- Existing services should be made more “male-friendly,” with service providers undergoing additional training and engaging in effective outreach activities.


\textsuperscript{36} Ibid.
The private health sector should be directly involved in efforts that foster male involvement.

Opposition and Challenges to Male Involvement

Most health-related policies do not specifically refer to male involvement and fail to offer suggestions for how to involve men in program implementation. Gender-related policies tend to overlook the concept of equality and the role of men in promoting women’s access to services and development opportunities. Implementing agencies that choose to involve men actively in their services receive little technical or financial support from the government.\(^{37}\)

Opposition to male involvement often comes from men themselves. Respondents point to men’s reluctance to change their practices regarding reproductive health, their feelings of embarrassment, and a belief that reproductive health, particularly birth spacing, should remain the concern of women. Evidence also suggests that men’s perception of risk limits their involvement in reproductive health. Another indicator of men’s perception of risk is the low rate of HIV testing, even among high-risk groups. Research by NCHADS concluded that 71 percent of the military and 81 percent of “motodop” drivers had never undergone an HIV test (NCHADS, 2001). It seems that men are either unclear about or refuse to acknowledge their own vulnerability and the danger to which they expose their partners.\(^{38}\)

Social, economic, and cultural challenges also pose barriers to involving men in RH matters. Barriers include the following: Unlike in the case of a visit to a pharmacy or

\(^{37}\) Ibid., pp. 3-4.
\(^{38}\) Ibid.
traditional healer, people fear that visits to doctors will involve invasive physical examinations. Such fear is often reported as a barrier to accessing health services.

i. Addressing men as a target group:

Several interviewers considered men to be beneficiaries of their programs because men were simply eligible for the services available. However, men were not specifically targeted in these programs. Other programs focus on specific target groups selected on the basis of their occupation (e.g., soldiers, police officers, construction workers, and garment factory workers) and the perceived risks associated with the various occupations.39

Focusing on specific target groups tends to overlook married men who live at home and have stable family lives but who also occasionally exhibit high-risk sexual behaviour and, as a consequence, put themselves and their wives at risk for STIs and unwanted pregnancy. Targeting the general male population as husbands, boyfriends, and individuals in need of improved and expanded health services is not yet a priority for RH agencies.

ii. Engaging men in reproductive health:

Respondents found that men were “uninterested” by RH, viewing it as not their concern. In particular, men believe that women should assume primary responsibility for birth spacing. However, decisions regarding sex ultimately rest with the man. Therefore, counselling for birth spacing must address cultural challenges. If contraceptive methods besides condoms are the method of choice, women will still have to bear the

39 Ibid.
responsibility for birth spacing, causing men to perceive that they can engage in sex without condoms.\textsuperscript{40}

Some sole-method choices for birth spacing, such as the pill, IUD, or injection, could help maintain men’s passive participation in family planning. Alternatively, promoting condoms as a dual method, such as in Population Services International’s efforts with its OK Condom brand, will help foster husband-wife sharing of responsibility for birth spacing and protect both from infection. As one respondent noted, although it is not always possible to change traditional values and men may always want to make decisions within the family unit, it is possible to change men’s perceptions. Men may therefore make choices that are good for themselves and their family.\textsuperscript{41}

iii. Addressing the perception of male and female roles:

Society’s expectations for male and female sexual roles are markedly different. Men’s needs for sexual variety and quantity are perceived as a priority while women are expected to be monogamous and uninformed. Traditionally, women look after the household; they are responsible for domestic labour and care of the family. They give birth and make decisions about their reproductive health. Men are the breadwinners; their needs generally come first, and they tend to monopolise scarce household resources.

These realities ensure that few financial resources are available for any member of the household in need care. Moreover, respondents noted that a man who patronises a specialised facility offering RH care is likely to feel ill at ease. It is women who

\textsuperscript{40} Ibid.
\textsuperscript{41} Ibid.
predominantly staff such facilities, which typically offer few distractions or IEC initiatives designed for a male audience.\textsuperscript{42}

\textbf{iv. Changing the environment in which RH care services are offered:}

Some respondents argued that the women-oriented environment for RH services - with its predominance of female clients and service providers - is a reflection of donor influence and emphasis on women’s concerns. It is undeniable that, in a country whose maternal and infant mortality rates are high, women are in urgent need of specific services. Donors have responded to that need, helping expand services that promote safe deliveries, ante- and postnatal care, safe motherhood, contraceptive availability, maternal and child nutrition, and immunisation.

A subsequent risk, however, is that, without careful planning, the exclusive focus on women will work against the involvement of men in RH. Such a possibility warrants further research and appropriate responses by donors and agencies involved in providing RH services. The exceptions would be male sterilisation, although it too would have little effect in promoting condom use.\textsuperscript{43}

The following recommendations highlight how the Cambodian government and NGOs could more actively support male involvement in reproductive health.

The recommendations are organised into three categories under the headings of policy, education and IEC, and service improvement.

\textsuperscript{42} \textit{Ibid.}
\textsuperscript{43} \textit{Ibid.}
A. Policy

- An important first step is to promote male involvement as a central tenet of reproductive health policy.\(^{44}\)

- A set of guiding principles needs to be developed to assist those involved in the health sector with mainstreaming male involvement into reproductive health strategies. The guidelines should be short, clear, and constructive and permit implementing agencies to adapt existing activities and approaches rather than initiating new projects or using additional resources.

- Agencies motivated to involve men in their reproductive health initiatives should plan for a long-term commitment.

- Any measure that seeks to challenge gender roles must be introduced and implemented as sensitively and as appropriately as possible. For example, men generally take little interest in family planning but may see themselves as the protector of the family and its financial provider. Therefore, educating men about the economic benefits of family planning might be more effective than attempting to persuade them to accompany women to family planning consultations purely on the basis of their responsibility as husbands and partners.\(^ {45}\)

B. Education and IEC

- Male involvement campaigns need to start finding ways to educate seemingly “safe” demographic and social groups. All men should be educated in all aspects of reproductive health as both direct beneficiaries and partners. A focus solely on

\(^ {44}\) Ibid.  
\(^ {45}\) Ibid.  

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traditional high-risk groups is no longer likely to succeed now that HIV/AIDS has spread beyond these groups.

- Current education campaigns need to be reviewed to assess their value in promoting male involvement. Programs that inadvertently stigmatise condom use so that it is associated only with high-risk situations may reduce condom use in non-commercial relationships.  

- Education campaigns should not reinforce gender inequities but rather work to reduce them. Programs should not, for example, put men in sole control of contraceptive choices.

- Education must be linked to service provision. Education will be insufficient without a clear understanding of what services are provided, how they can be used, and in what way they benefit both individual males and their families.  

- Establishing effective ways of delivering education messages to the male populace requires greater analysis. Outreach services that use role models and structures familiar to the client base may sometimes be more effective in reaching men than merely encouraging clinic use, which is often seen as the domain of women. An instructive example is the uniformed services, which respond well to peer education techniques. Conversely, men who have sex with men (many of whom also have sex with women) may respond better to methods that do not depend on personal contact, such as radio and television broadcasts.

\[46\text{\textit{Ibid.}}\]

\[47\text{\textit{Ibid.}}\]
• The mass media should be used more frequently and more effectively. Radio is widely accessible and can reach even highly mobile groups such as fishermen and the military. Television is hugely popular with the urban young.

• Traditional role models, including community and religious leaders, should be promoted to men. The visible support of influential people in the community (most of whom are men) reportedly encourages people to perceive health programs as relevant and socially acceptable.48

• Teaching negotiation skills should be accompanied by efforts to raise awareness of the legitimacy of challenging gender stereotypes and not accepting them as the norm.

C. Service Improvement

• Existing RH services should be more “male-friendly.” Understandably, specialised RH care facilities are female-oriented. While such facilities are essential and successfully provide much-needed RH support to women, they are generally perceived as inaccessible to men, thus embarrassing or intimidating prospective male clients. Certain basic measures that would begin to address such gender issues include the hiring of male service providers, reassessing clinic opening times, and perhaps scheduling male-only clinics and improving the privacy of male clients.

• Existing service providers need further training in counselling male clients and couples. Service providers must be trained according to the specific priorities of a program and its beneficiaries. For example, some providers work with large numbers of clients concerned with HIV/AIDS.49

48 Ibid.
49 Ibid., pp. 5-7.
• Effective outreach activities need to be developed to facilitate both men’s and women’s access to RH services. Furthermore, community based distribution networks have been shown to have an impact in facilitating the access of rural people to some contraceptives, particularly condoms, often because such networks ensure greater privacy, help reduce transport costs, and offer greater convenience.

• Male involvement should be supported by efforts to facilitate access to RH services. Distance, cost, social and cultural barriers, limited awareness, and perceived efficacy of treatment are important factors in influencing the use of public health services.\(^{50}\)

• A study in Egypt evaluated the impact of counselling husbands of abortion clients on their level of support post abortion. The main education and counselling themes for the husbands included: (1) the woman's need for rest and nutrition, (2) post abortion warning signs, (3) return to fertility with two weeks, and (4) the need for family planning. The overall impact of the counselling was small, but among subgroups there were some significant effects.

For example, among couples with no female members at home to help in the recovery process, the husbands who received counselling were significantly more likely to provide a high level of support to their wives. The counselling was acceptable to both husbands and wives. It was concluded that, as long as the woman's right to privacy is protected, counselling of husbands should be included in post abortion care services.\(^{51}\)

\(^{50}\) Ibid.

Another study evaluated the role of involving prospective fathers in the care of pregnant women attending a clinic in Bombay, India. Beginning in October 1982, pregnant women attending the Clinic were requested to ask their husbands to meet with the resident medical officer of the centre.

The outcome of the maternal health care program for the 270 women whose husbands were invited and came (Group 1) was compared with the outcome of the same program for 405 women whose husbands could not be invited (Group 2).

The husbands who attended the centre were educated individually and in groups about their role in nutrition and health of their wives during pregnancy and their responsibility in subsequent child rearing. The physiology of pregnancy, complications of pregnancy, and the possible ways and means of preventing the complications were explained in detail. The husbands also were told to encourage their wives to attend the antenatal clinic of the centre as often as possible. The main difference between the two groups was a significantly lower perinatal mortality in Group 1. Furthermore, more women in Group 1 accepted postpartum sterilisation than women in Group 2. This effort confirms that the involvement of prospective fathers is possible and pays good dividends even in an uneducated and low socio-economic community.

Another study examines the experiences of the staff of New Ways in Health Education in conducting men's programs. The key problem in developing health programs for men is with the pervasive, rigid roles in which men are placed almost from

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53 Ibid.
birth. The lack of male involvement in family planning is part of an overall failure to involve men in health care programs in general.

Strategies for outreach to men generally have fallen within four groups: no strategy (simply opening a clinic and waiting for male clients), female model (using a successful female recruiting method to recruit males), macho modelling (endorsement of male involvement in contraception by highly regarded figures) and the male oppression strategy (focusing on the idea that men are as oppressed as women).

These approaches have been ineffective and simply promote the rigid adherence to the male role that undermines the ability to involve men in caring and responsible roles in their sexual relationships.

A new strategy involves two key assumptions: that the full involvement of men in family planning would be of enormous value to everyone concerned, and that while women bear the greater burden of the rigid sex-role expectations in this society, men also are hurt by these roles. The chapter provides examples of programs dealing with partners of abortion clients, teenagers, and men concerned about infertility and presents special techniques for counselling men.54

**Strategies to promote male family methods like Vasectomy**

- Provision of an attractive incentive.
- Aggressive educational campaign focussing particularly to men.
- Detailed and focussed counselling of men explaining both the advantages and disadvantages of the methods.
- Increased availability of operation facilities and regular vasectomy camps.55

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One more strategy for male involvement in Reproductive Health can be detailed as below. The intervention consists of three parts: (1) community, (2) health facility (public, private and traditional), and (3) an integration component. The program included a formative research phase, a population-based baseline survey of behavior and biological markers of HIV risk, the development of an intervention, and detailed process evaluation. The intervention consisted of an integration component that was designed to foster and prevent duplication through Technical and Community Advisory Groups.

The community component was built upon Quality Life Clubs (QLC), which were introduced at each of the project sites targeting residents in the inner city hostels and informal settlements with the aim of building the capacity of individuals who attend the clubs to move from survival mode to one where they can cope and respond to daily stresses and shocks and move towards aspiring to a better life. Members met twice a week for 6 months to learn, reflect and change and mobilized urban communities. Three rounds of the 6-month “Learn, reflect, change” program were implemented. The QLC was primarily aimed to address HIV/AIDS with the club members, who after a few months of affecting change in other areas of their lives, will be receptive to discussions around behavior change, specifically relating to HIV prevention, testing, treatment access and wellbeing.\(^{56}\)

A community-based organization, Sipho Eshihle (Precious Gift) attempted to ensure the sustainability of the QLC approach beyond the life of the donor funding cycle to lead the QLCs in this area, with the support of local organisations. QLCs furthermore

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were used to forge stronger ties between residents and government services, ensuring issues relating to rights, participatory decision-making and citizenship are addressed.\textsuperscript{57}

**Factors involving Male Involvement:** A conceptual Framework developed shows that male involvement in Reproductive health is affected by an array of factors. They are perception of reproductive health services by couple and their attitude towards the utilisation of these services. These factors are again influenced by gender inequalities and Information, Education and Communication strategy, female orientation of family planning programme, availability and accessibility of services and contraceptive technology.\textsuperscript{58}

\begin{figure}  
\centering 
\includegraphics[width=\textwidth]{diagram.png} 
\caption{Factors Influencing Male Involvement in Reproductive Health} 
\end{figure} 

\textsuperscript{57} AIDSTAR – ONE website from USAID