Chapter-I

INTRODUCTION

The right to development is fundamental, with the right to reproductive health being crucial for rural development, for supporting poverty reduction and for fulfilling the goals on maternal mortality, empowerment for women, HIV/AIDS. Economic growth is important for increasing revenues for social sector investments but alone does not guarantee better reproductive health status of the rural poor, especially those living in extreme poverty with limited access to basic health and education. Rural economy has a link with rural health in particular with Reproductive Health. Poor Reproductive health creates problems like: I) weakening and killing poor women of prime ages; II) disrupting and making short the lives of their children; and III) placing heavy financial and social burdens on families. Reproductive health is thus a critical cross-cutting factor for rural development.

The private nature of sexual and reproductive health does not diminish its significance. At least 120 million couples worldwide would like to limit their family size but are not currently using a method of contraception. Each year, nearly six lakh women die from conditions related to pregnancy and childbirth, and 40–50 million pregnancies are terminated by abortion. The incidence of reproductive tract infections, especially sexually transmitted diseases (including the human immunodeficiency virus), is increasing dramatically. Some five lakh women develop cervical cancer each year. There is also the problem of violence in relation to reproductive ill-health. Battery during

pregnancy, sexual coercion, rape and female genital mutilation are just some of the issues that require urgent attention in this regard.[1]

Historically men have been dominating in human society since the origin of civilisation on the earth. Man is comparatively stronger and powerful than the woman in respect to physical, social, economic and cultural spheres of life. The men take most of the decisions. Women are considered as poor, low profile, power less and dependent in most of the developing countries. Ironically many of our Reproductive health programs involve men in a poor way. This is disturbing the effectiveness of these programs.

In the International Conference on Population and Development (ICPD), 1994, about 180 representatives from different countries agreed to improve male participation in the Reproductive and Child Health (RCH). It has been also pointed out and accepted in several international, national, state levels conferences and meetings that equality and equity based gender partnership in the field of RCH and family planning should be increased. It was universally and unanimously recognised that support and effective partnership of males can contribute to the women status, education, health, and overall development and welfare.[2]

There is a growing understanding in the international public health community about the role of gender as a fundamental influence along with decision-making power,

[1] Khanna J. (1998). "Reproductive health research: the new directions, Biennial Report 1996-1997", Biennial Report of the UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction, World Health Organisation, Geneva, Van Look PFA, eds, p.1.

[2] Ramakanth Sharma (2006-2007). "Level of Men's participation in reproductive and child health among rural communities of the Rajasthan", Population research centre, Udaipur, Mohanlal Sukhadia University, p.7.

access to education and earning power; it affects the health choices available to everyone. This understanding has been instrumental in making reproductive health professionals aware of the needs to develop creative strategies to reach men – a need that has become increasingly urgent in the face of the growing worldwide spread of sexually transmitted diseases (STDs), including HIV infection.[3]

The similar approach is needed in India too to concentrate more on involvement of men in Reproductive Health. Most WHO regions and member states on the basis of above guiding principles built strategies regarding development of regional and country reproductive health strategies which focus on reduction of maternal mortality and severe morbidity related to pregnancy and childbirth as a top priority component of reproductive health programmes. Male involvement and participation in the implementation of these strategies is also underscored, given the role of men as leaders and decision-makers at household, community and policy levels. However, it is widely recognised that men are often marginalised by maternal health services and are provided with limited access to basic information and knowledge to help them make informed choices and decisions in order to protect and promote their own health as well as that of their families.[4]

Males support and effective partnership can contribute and improve the women status, education, health, economic independence and overall welfare and development of Indian population just not confined to Reproductive Health. Most of the reproductive health programs administered by the Indian government have neither included men as a

[3] *Ibid*.

[4] Ramakanth Sharma (2006-2007). "Level of Men's participation in reproductive and child health among rural communities of the Rajasthan", Population research centre, Udaipur, Mohanlal Sukhadia University, p.8.

target audience for IEC activities nor promoted their involvement in reproductive health or family planning programs. Under new population policy, Indian government has also introduced several interventions in improving the male involvement in all stages and ways of RCH policy, action plans and programs.[5]

Sexual and reproductive health encompasses both positive and negative dimensions of well-being. This does not mean merely that disease is either present or absent. Rather, sexual and reproductive health incorporates both pleasure and danger: on the one hand comfort, physical closeness, sexual intimacy and mutually respectful relationships; and on the other, fear, distress, sickness, disability and even death.

Human relationships are especially important. A person's sexual and reproductive health is directly related to his or her intimate relationships. Improving a person's sexual and reproductive health, on the other hand, calls for an understanding of the individual's social network and relationships over time. In sexual and reproductive health, universal definitions do not tell the full story. A "healthy" pregnancy, for instance, may nevertheless cause distress to a woman who does not wish to be pregnant and in some cases may lead her to risk her life to terminate it.[6]

Sexual and reproductive health calls for bold new thinking about which interventions are best and who can best carry them out. It points to a multi-sectoral approach that will involve education and even legal aid organisations and criminal justice

[5] *Ibid*.

[6] Khanna J. (1998). "Reproductive health research: the new directions, Biennial Report 1996–1997", Biennial report of the UNDP/UNFPA/WHO/ World Bank Special Programme of Research, Development and Research Training in Human Reproduction, World Health Organisation, Geneva, Van Look PFA, eds, p.2.

systems. The distinctiveness of sexual and reproductive health has implications for research too. Just as new perspectives are essential, new research topics, questions and approaches are required.

This thesis is a piece of such work in the field of Reproductive Health. It aims to thought provoking to Government and Non Government Organisations to improve quality of reproductive health in the given region.

As part of the new agenda for sexual and reproductive health, research will be based on four basic principles:

- First, research will address the broad context of sexual and reproductive health, and not just fertility regulation. The urgent need to respond to the AIDS pandemic, for instance, has led to the recognition that sexuality and sexual health are important.
- Second, research will take as its starting point the needs of women and men at different stages in their lives. Young people deserve special attention; not least because youth is a stage at which behaviour patterns are formed that can have important influences on sexual and reproductive health later in life.
- Third, research will incorporate a gender perspective. It will look at the social roles and identities of males and females and will examine how the imbalance of power between men and women affects sexual relationships, fertility regulation and reproduction.
- Fourth, research will contribute to greater equity. It will seek to reduce unfair burdens and address the needs of disadvantaged groups. This means for instance, reducing the burden of contraception on women, attending to the high cost of sexuality and reproduction to women, and meeting the needs of marginalised, vulnerable and underserved groups.[7]

[7] WHO (1998). "Progress in Reproductive Health Research", *Quarterly Newsletter* published by WHO under HRP (Special programme of Research and Training in Human Reproduction) No. 47, Part-I, pp. 2-3.

Men and Reproductive Health

The general objective of the concept is to promote gender equality in all spheres of life…and to encourage and enable men to take responsibility for their sexual and reproductive behaviour and their social and family roles.[8] Women have long been the almost exclusive focus of national and international reproductive health programmes. Services for men and interventions aiming their involvement in Reproductive health have been relatively few. More recently, however, male involvement in reproductive health has become a popular theme among reproductive health programme designers, policy makers, and population researchers.

In the last few years, more attention has been focusing on the issue of male involvement in reproductive health, and as its importance is acknowledged, more programmes are trying to incorporate it as one of their components. However, existing programmes tend to share potentially problematic aspects: first, male components are usually limited to male methods of family planning, only one element of reproductive health. [9]

Second, they tend to address men only, in a similar way as the old programmes addressed women only without taking into account their gender relations. A focus on men only is as inadequate as a focus on women only because it fails to take into account the way in which many decisions are made and the context that influences them. Third, they tend to be grounded on a negative premise, men's irresponsibility, rather than a positive

[8] UNFPA (1995). Chapter-IV, "Gender Equality, Equity and Empowerment of Women" Summary of the Programme of Action United Nations International Conference on Population and Development (ICPD), Cairo, Published by the United Nations Department of Public Information * DPI/1618/POP--March pp: 1

[9] UNFPA (1998). "Male Involvement in Reproductive Health: Incorporating Gender throughout the Life Cycle," Technical Support Services System, Occasional Paper Series No. 1, June, p 1.

one of promotion of men's rights. Fourth, by viewing men as a route for women's well-being they instrumentalise men and fail to address men's needs.[10]

These problematic aspects emanate from:

- A female bias in the gender literature, and the consequent lack of knowledge of the male side of gender. The gender literature tends to be by women on women.
- The traditional inability to set up programmes on the understanding of gender relations, disregarding the power relations and the gender roles that influence decision-making related to reproductive health.
- The way in which programmes were traditionally institutionalised, through the maternal and child health (MCH) facility of the Ministry of Health, that focused on women (and children, in the traditional dyad) and barred men from access to services and from exercising a number of responsibilities in the area of reproductive health of their wives and health of their children.
- Commonly held myths and erroneous assumptions about men's views of family planning, sexuality and health.[11]

The lack of data to understand male perspectives and the extent of their involvement in reproductive health issues. The surveys most relied upon for reproductive health (RH) programmes usually ask questions only of women, assuming that they are the ones who make the decisions regarding reproduction and that the men are either not involved or marginally involved.

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[10] *Ibid*., p. 1.

[11] UNFPA (1998). "Male Involvement in Reproductive Health: Incorporating Gender throughout the Life Cycle," Technical Support Services System, Occasional Paper Series No. 1, June, p.1.

Men are an important focus for reproductive health services, not only because they have their own concerns in this area, but also because their health status and behaviour affect women's reproductive health. Men can support their partners' health seeking behaviour , they can help prevent the spread of sexually transmitted infections and can stop the violence in the family.

There is a growing understanding in the international public health community of the role of gender as a fundamental influence; along with decision-making power, access to education and earning power; it affects the health choices available to everyone. This understanding has been instrumental in making reproductive health professionals aware of the need to develop creative strategies to reach men--a need that has become increasingly urgent in the face of the growing worldwide spread of sexually transmitted diseases including HIV infection.[12]

Gender relations should be understood prior to formulating strategies to involve men in Reproductive and Sexual Health. A better understanding of gender relations could shed light on the dynamics surrounding decision making and generate hypotheses as to the reasons behind the perpetuation of the practice.

Reproductive health was defined as a question of women's health, rights and empowerment, rather than a medical question of Reproductive Tract Infections, Urinary Tract Infections and Sexually Transmitted Diseases. Although reproductive health has

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[12] Mary Nell Wegner, Evelyn Landry, David Wilkinson and Joanne Tzanis (1998). "Special Report, Men as Partners in Reproductive Health: From Issues to Action", International Family Planning Perspectives, published by Guttmatcher Institute, Vol.24, No.1, March, p.1.

traditionally been viewed as a medical issue, provision of medical services alone will not lead to significant improvements in women's health. A key underlying factor that influences women's reproductive health status is the complex web of gender relations and power structures that bars women from participating in crucial decisions that affect their reproductive lives. Thus the key challenge for advocacy is getting reproductive health program to address issues of power and gender relations.[13]

Traditionally, issues of reproductive health have been considered "women's issues", an area where men are the forgotten factor. As women are the ones who become pregnant, they have, all too often, been made to deal alone with the potential consequences of being sexually active – be it decisions on contraception or even abortion, or bearing and rearing children. Many men, especially those in stable relationships, do take on their share of responsibility for reproductive health choices and fully support their partners. However, even after the advent of HIV/AIDS, some men – especially young men – shirk their responsibilities.[14]

There are several areas of reproductive health which should (and do) concern men as much as women: family planning, men's sexual health (sexually transmitted diseases, including HIV/AIDS, and other illnesses such as cancer) and men's reproductive health (especially the rise in male infertility). Men should thus be encouraged to get more

[13] Rosmarie (2004). "The involvement of men, especially young men, in reproductive health", Doc. 10207, Report by Committee on Equal Opportunities for Women and Men, Zapfl-Helbling, Switzerland, Group of the European People's Party, 10 June, p. 1.
[14] *Ibid*.

involved in family planning and in looking after their own sexual and reproductive health.[15]

To this end, education, information and advice on reproductive and sexual health has to be specifically targeted at men, as well as at women, and their needs. In particular, family planning providers, governments and NGOs should look at ways of reaching out to young men and supporting them in their reproductive and sexual health choices.

Men's reproductive health has been so far a neglected area. Women as they directly take up child bearing and rearing are presumed to be exclusively responsible for better reproductive health. Thus, the focus of most programmes and service provision in this field has until recently been on family planning and safe motherhood services.

Though research has been conducted on reproductive health, it is confined to understanding the perspectives and needs of women - as users of contraceptives, as pregnant women, as women in labour, and as mothers. As a result of this focus, for example, research into new contraceptive technologies has concentrated only on finding effective female methods of fertility control but did not touch male methods.

The Intra Uterine Devices, hormonal pills and injectables, hormonal implants and tubal ligation do not interfere with the sexual act and thus do not require direct male involvement. These methods provided women with the means to control their own body and fertility. This again increases burden on women in addition to other tasks and family planning is often presumed to be just women's business.[16]

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[15] *Ibid*., p. 1.

[16] Dr Sarah Hawkes and Dr Martine Collumbie (2001). "The sexual health of men in India and Bangladesh: what are men's concerns? Programming for male involvement in reproductive health", Report of the meeting of WHO Regional Advisers in Reproductive Health, September, p.88.

Following the International Conference on Population and Development (ICPD) in 1994, there has been a great deal of commitment to move away from demographic targets towards a broader focus on human welfare, individual choice and the goals of gender equality. As a result, there has been a programme-level shift away from vertical family planning services and towards the provision of comprehensive integrated reproductive health (RH) care at all levels of health sectors. The Government of India, for example, has stated that the principles guiding reproductive health service delivery are that they should be 'Client-centered, demand-driven, high quality, integrated services'.[17]

Reproductive health generally has been considered as synonymous with women's health, and hence reproductive health of men has received little attention. In a society like ours predominated by the males, declining sex ratio for females, increasing number of women with sexually transmitted infection including HIV, increasing unintended pregnancies and induced abortions including unsafe abortions, higher IMR, suggests that women bear the brunt and carry the burden of reproductive ill health which can be prevented to a certain extent by active participation of men.

Male methods

Despite calls for men to take greater responsibility for family planning, the methods available to men remain the condom and vasectomy. Research must work to provide men with new options that can fill the wide gap between a barrier method(condom) and the permanent suppression of fertility. However, one target of research is the epididymis; development of an agent that would disrupt neither the

[17] *Ibid.*

production of sperm nor the secretion of the male hormone testosterone could lead to a male contraceptive that does not interfere with potency and yet prevents sperm motility or egg recognition and binding. Far more research is needed to understand what might be effective in influencing male reproductive attitudes, practices and behaviour.

AVSC International gave an overview of their Program entitled Men as Partners (MAP) developed during the past four years. The programmer's goals are to: increase men's awareness of and support for their partners' reproductive health choices as well as their awareness of the need to safeguard reproductive health, especially through the prevention of STDs; increase the use of contraceptive methods that require the participation of men; and improve men's access to comprehensive reproductive health services.[18]

In order to analyse the hierarchical gender system in any given society one must begin with a basic assessment of social structure. Gender perspectives (including those concerning reproductive health and sexuality) are embedded in this larger structure. It is thus necessary to identify the salient characteristics of social structure for each region (or sub-group of interest) and assess its implications for the gender system.[19] The same exercise has been done in current thesis to capture social conditions of respondents also.

Terminology: The movement to involve men in reproductive health has many names, including men's participation, men's responsibility, male motivation, male involvement,

[18] Engender Health (1997). "Men as Partners in Reproductive Health", Workshop Report, New Delhi, p 1.
[19] John M. Pile, Cigdem Bumin, G. Arzum Ciloglu, Ayse Akin (1999). "Involving Men as Partners in Reproductive Health", Lessons Learned from Turkey, AVSC Working Paper, No. 12, June, p.1.

men as partners, and men and reproductive health. Men's participation can be seen as a means to an end, rather than as a goal in itself.

Why Involve Men?: Men's participation is a promising strategy for addressing some of the world's most pressing reproductive health problems. With HIV now spreading faster among women than among men in some regions, the AIDS epidemic has focused attention on the health consequences of men's sexual behaviour. Also, millions of pregnancies are unintended, and each year many thousands of women die as a result of these pregnancies.

Men have their own sexual and reproductive health concerns and needs which are not always met. The focus on male involvement only as a means to improve women's reproductive health may cause an oversight of men's own reproductive health needs. Due to their ascribed gender roles, men tend to have little knowledge about their own physiology and health including sexual and reproductive health.

Men's health status and behaviour affect women's health and reproductive health. Involving them increases their awareness, acceptance and support to their partners' needs, choices and rights. In terms of contraception, for example, it means encouraging them to give more support to their partners who use female-dependant methods. In terms of HIV prevention, all methods except for the female condom, are male controlled, therefore there is a need to involve men in this domain. The ICPD Plan of Action underlines the importance of having men "accept the major responsibility for the prevention of sexually transmitted diseases".[20]

[20] PAN - American Health Organisation (1994). "Involving men in Sexual and Reproductive Health: Why & How?" - International Conference on Population and Development by UN, Gender and Health Unit, Cairo:1-5.

Talking of female alone or male alone is not an adequate approach to reproductive health issues. Many of the decisions regarding reproductive health and family planning are made within a set of gender relations that affect them or their implementation. More attention should be paid in identifying to what extent each one of the methods requires co-operation and support of both sexes and its implications on the health and sexual relationship of both partners.

Involving men in reproductive health has been found to have a positive impact on women's and children's health in a number of ways, including improving Maternal and Child Health care, preventing or reducing STI/HIV/AIDS transmission, and improving contraceptive use-effectiveness and continuation. A study on the impact of providing antenatal education to prospective fathers in India found a significantly higher frequency of antenatal clinic visits and significantly lower perinatal mortality among the women whose husbands received antenatal education.[21]

Furthermore, men participating in antenatal education tend to know more about family planning methods and are more concerned about their partner's nutritional needs during pregnancy.[22] Research has shown that married women's greatest risk factor for STIs is the sexual behaviour of their husbands. Men are much more likely (eight times) to transmit HIV to women through repeated acts of unprotected sexual intercourse than vice

[21] Bhalerao, V.R. *et al*. (1984). "Contribution of the education of the prospective fathers to the success of maternal health care programme", *Journal of Postgraduate Medicine*, January 30(1), pp.10-12.

[22] Raju, S. and Leonard, A., eds. (2000). "Men as Supportive Partners in Reproductive Health: Moving from Rhetoric to Reality", Population Council. Available at: www.popcouncil.org/pdfs/menaspartners.

versa.[23] Studies have shown that involving men can increase contraceptive adoption, client satisfaction, contraceptive use-effectiveness, and contraceptive continuation. Randomised trials have found that contraceptive adoption was significantly higher among women whose husbands were included in contraceptive counselling compared to women whose husbands were not involved [24]

A recent randomised study in China has demonstrated improvement in contraceptive use-effectiveness for couples when the husband was involved in contraceptive counselling.[25]

Several studies have shown higher contraceptive continuation among clients whose husbands have been involved in contraceptive counselling. A study in Madagascar found that women were more likely to continue using Norplant implants if their husbands had been involved in the counselling process [26]

A publication of UNFPA (1995) lists the following reasons for the growing importance of male-involvement initiatives in family planning:

- The advent of the AIDS epidemic has spurred intense interest in condom promotion;

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[23] Padian, N.S. *et al*., 1997, "Heterosexual transmission of human immunodeficiency virus (HIV) in northern California: results from a ten-year study", *American Journal of Epidemology*, August, 146(4), pp.:350-357.

[24] Fisek, N.H. and Sumbuloglu, K. (1978). "The effects of husband and wife education on family planning in rural Turkey", *Studies in Family Planning*, October–November.9(10–11), pp.280-285.

[25] Wang, C.C. *et al.* (1998). "Reducing pregnancy and induced abortion rates in China: family planning with husband participation", *American Journal of Public Health*, Vol. 88(4).

[26] [26]Tapsoba, P. *et al*. (1993). "Involving Husbands to Increase the Acceptability of Norplant in Antananarivo, Madagascar", Paper presented at the 121st Annual Meeting of the American Public Health Association, San Francisco, California, October, pp.24–28.

- Men are more favourable to the general principle of family planning than has been assumed;
- Male support affects both the adoption and the correct use of female contraceptives;
- Male-involvement programs can be cost-effective if they are highly focussed and offer male contraceptive methods directly or by referral;
- Men's role in the abuse of reproductive rights and sexual violence directed towards female partners and relatives should no longer be ignored; and
- The international consensus reached at ICPD has created a momentum for action.[27]

Developing new approaches for increasing men's involvement in improving reproductive health will require a research agenda that is gender-sensitive, addressing the roles of both men and women. Research will need to examine how men and women interact within sexual unions, including the way in which sexuality and reproductive processes are viewed, and how decisions about family size are reached and contraceptive choices made. Increased male involvement implies major shifts in men's perceptions of, and attitudes to, sexuality and reproduction. Research is needed to provide data on the perceptions of men and women to policy-makers and planners. Research in these areas will not be easy, but it is necessary if gender inequity is to be overcome.

Men have an important influence on women's and children's health and also have distinct reproductive health needs of their own. In many cultures, men also may serve as gatekeepers to women's access to reproductive health services. Research and program experience are demonstrating that many men care about and are willing to make positive

[27] Khan, M.E., Bella C. Patel (1997). "Male Involvement in Family Planning", A KABP study of Agra District, India, Final Report, *Population Council*, June, p.1.

contributions to the reproductive health of their partners and well-being of their families. Despite the surge of interest in this area, there is a lack of consensus about what it means to involve men in reproductive health programs and uncertainty about how such involvement will affect women's health and status.[28]

Some women's groups feel, however, that such a move might undermine women's self-determination still further. Social science and behavioural research is needed to examine the ways in which men and women interact (and differ) with regard to attitudes and behaviour that have an impact on sexual and reproductive health. This means using a gender perspective that includes the perceptions of both men and women. Many providers and program designers have concluded that neglecting men and their reproductive health is a losing strategy with adverse consequences for both men and women. As a result, interest in and commitment to involving men in reproductive health has intensified during the 1990s.

The reasons for more attention to men in precise include:

- Growing concern about the spread of HIV/AIDS and other STDs, such as chlamydia and gonorrhea.
- Evidence of the ill effects of some men's risky sexual behaviour on the health of women and children
- Survey findings that many men approve of family planning [29]

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[28] ‘‘Men and Reproductive Health Subcommittee of the U.S. Agency for International Development's Interagency”, Gender Working Group, Men and Reproductive Health, Reproductive Health Outlook website, p. 2.

[29] Megan Drennan *et al*. (1998). “Population reports published by Population Information Program”, Centre for Communication Programs, *The Johns Hopkins School of Public Health*, Vol.XXVI, No.2, October, Series J, No.46.

Male Involvement in reproductive Health not only implies contraceptive acceptance by men, but also refers the need to change men's attitude and behaviour towards women's health, support women using health care services and sharing child rearing activities.[30]

- Greater recognition that in many cultures men make decisions that affect women's reproductive health as well as their own
- Increasing awareness that gender-men's and women's differing social roles and the power associated with these roles-affects sexual behaviour, reproductive decision-making, and reproductive health in many different ways
- Demands from female health care clients that men become more involved and included in family planning and other reproductive health care[31]

Services for men

Family planning and reproductive care has traditionally been women's domain. One of the greatest challenges for researchers is to develop appropriate models for providing reproductive health services for men. A crucial issue in the development of such models will be how to motivate men to use the services.[32]

Equality between men and women begins in the family. Understanding gender discrimination means understanding opportunities and constraints as they affect men as well as women. In particular, the assumption that contraception, pregnancy, childbirth

[30] Abhilasha Sharma (2003). "Male Involvement in Women Reproductive Health, Paper presented at the Millennium Conference on Population", Development and Environmental Nexus and XXIII Annual Conference of the Indian Association for the study of Population held in New Delhi, February 14-16, Vol 49, No.1, June, p.1.

[31] World Health Organisation (1998). "Men's role in Improving Reproductive Health. Progress in Reproductive Health Research", Biennial Report of the UNDP/UNFPA/WHO/ World Bank Special Programme of Research, Development and Research Training in Human Reproduction, Geneva, No.47, Part 1, p.7.

[32] *Ibid*

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.[33]

In a culture like Indian, where patriarchy is accepted as the only proper family structure, men and women may be trapped in a pattern of relationships and dependencies that can frustrate them both. A woman without a husband may have no social standing, and have difficulty even finding the means of survival: but a man too may find life hard without a wife to do "woman's work"-grow food, cook and bring up children.[34]

Men who cannot live up to expectations that men should be powerful and competent may respond by retreating into passivity and escape through drugs or alcohol, by resorting to violence towards those still weaker, or by exhibiting exaggerated bravado and risk-taking. Hence men should be helped to have good reproductive health, which in turn affects his total behaviour to an extent. [35]

Men especially cannot be left while addressing these issues as they have continued to be the major decision makers including the health seeking behaviour, prevention of RTIs, STIs and HIV and also decreasing violence. All these may be concluded after conducting a baseline study where the opinion of community is taken regarding men's involvement.[36]

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[33] UNFPA (2000). "Men, Reproductive Rights & Gender Equality", Chapter 4, State of World Population, p.1
[34] *Ibid*., p. 2.
[35] *Ibid*., p. 4.
[36] Kate M Dunn, Susmitha Das and Rumeli Das (2004). "Male Reproductive Health: A village based study of camp attenders in Rural India", Reproductive Health, Dunn *et al*; licensee BioMed Central Ltd., Vol 1, p.7.

Furthermore, women earn a significant proportion of family income; yet dominated by men in many aspects. Men also hold most of the positions of authority in the government and civil service and are managers in both the public and private health sectors. Involving men in Reproductive Health is therefore essential in order to draw attention to women's rights and improve the health status of both men and women.[37]

Targeting men as beneficiaries of RH care and as supportive partners could address high rates of maternal and infant mortality and reduce the overall total fertility rate by increasing contraceptive prevalence, choice, and access to appropriate services and trained personnel. Targeting men as service providers will improve and expand the services offered by the private and public health services. Targeting men as policymakers will facilitate progress toward national development goals and help mainstream gender equity in legislation and service implementation.[38]

Men can advance gender equality and improve their family's welfare by - Protecting their partners' health and supporting their choices - adopting sexually responsible behaviour; communicating about sexual and reproductive health concerns and working together to solve problems; considering adopting male methods of contraception (including vasectomy and condoms); and paying for transport to services and for service costs; Confronting their own reproductive health risks - learning how to prevent or treat sexually transmitted infections, impotence, prostate cancer, infertility, sexual dysfunction and violent or abusive tendencies; - Refraining from gender violence themselves and opposing it in others and promoting non-aggressive conceptions of male

[37] Naomi Walston (2005). "Challenges and Opportunities for Male Involvement in Reproductive Health in Cambodia", Policy Project/Cambodia, pp. 1-2.
[38] *Ibid*.

sexuality and masculinity; Practising responsible fatherhood - supporting their partners in child rearing and household tasks; protecting their children's health and investing in their future; teaching their sons respect for women's needs and perspectives; developing open and supportive relationships with their daughters; and providing their children with accurate and sensitive information; Promoting gender equality, health and education - supporting the education and training of girls and women; promoting women's participation in health, education and economic activity; lobbying for increased funding for basic social services and working to improve the quality of programmes; and demanding that family life education be taught in schools.[39]

The following set of activities is suggested to give a masculine dimension to the reproductive health programmes at a national level to encourage male responsibility.

- Reorganisation of reproductive health services make services available in work place and other male dominated areas.
- Integrate men's reproductive health into existing services.
- Organise advocacy activities to motivate men to utilise reproductive health services, primarily by targeting men and secondarily by focussing on male opinion leaders and men's organizations and also by generating political will and support.
- Encourage coalition with wives on matters of reproductive health.
- Revise training curricula to include the offering of men's reproductive health services
- Develop messages that are relevant and acceptable to men; choose appropriate messengers (IEC)

[39] .Sachar, R.K., Prof. Deptt, of Community Medicine, Dayanand Medical College & Hospital (2003). "Dhanwantri oration strategically orienting reproductive health encouraging male responsibility", *Indian Journal of Community Medicine,* Ludhiana, Vol. XXVIII, No.2, Apr-June, p.59.

- Research in reproductive health problems of men. - Promote positive role model images.
- Use of simple inbuilt evaluation indicators like number of men or couples visiting facilities providing reproductive health care.[40]

The word "Reproductive Health" implies both men and women. Men are partners in reproduction and sexuality. Men's reproductive health and their behaviours impact on women's reproductive health and children's well-being and society as well. Comprehensive male involvement includes:

1. Encouraging men to become more involved and supportive of women's needs, choices, and rights in sexual and reproductive health; and
2. Addressing men's own sexual and reproductive health needs and behaviour.[41]

Andhra Pradesh, a state where about 100 targeted interventions for HIV prevention and many more by Reproductive and Child Health project by various Government and Non Government agencies are addressing the sexual and reproductive health needs could find a gap between knowledge and action. A balance in involvement of both the genders is the key factor for success of all these interventions.

The present study was undertaken to assess the knowledge of men and women regarding reproductive health and their opinion about men's involvement in reproductive health.

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[40] *Ibid*.
[41] *Ibid*., p. 60.

PROFILE OF ANANTAPUR DISTRICT

Anantapur has 63 revenue mandals from three revenue divisions namely Anantapur, Penukonda and Dharmavaram. Being fallen in rain shadow area, it is the driest part of the state and the agriculture conditions are difficult. Being far off from east coast monsoons seldom touch this part and is drought pone. In order to study the above objectives the study was conducted at Anantapur. About 14 per cent of the total population belongs to Scheduled Caste while 3.49 per cent belongs to Scheduled Tribes. District which is a border district of Andhra Pradesh and has population with different cultures. Poverty and illiteracy are the main challenging tasks in this district. The literacy rate is only 49.75 per cent. Still some of the people believe in traditions like Devadasi system. Child marriages are very high in the District. High indebtedness, increased out migration and high number of farmers' suicides are the characteristics of the District. Malnutrition, illiteracy, illness, factionism, caste and gender discrimination are rampant.

Thus, a study in this District may help as baseline for the future interventions in this area. The Mandals are taken from three corners of the District representing the total District.

NEED FOR CURRENT STUDY

Being a backward District, it deserves a good alternative for improving Reproductive health of men and women. Maternal, Infant and neonatal mortality can be reduced by addressing health issues. By improving Reproductive health the economic levels of the people can be improved by increasing their productivity. Population density can be decreased by sensitising both men and women about Family planning which will

increase resource availability per family member. The study of knowledge, attitude and practices of men and women regarding Reproductive health gives a clear picture of requirements for future interventions. Such studies are very rare and are helpful for policy decisions in terms of Gender equity in Reproductive Health.

OBJECTIVES OF THE STUDY

- To find out the general fertility preferences of selected men and women
- To study the spousal communication and decision making regarding reproductive Health.
- To assess the knowledge of selected men and women regarding family planning and compare.
- To assess the knowledge of selected men and women regarding HIV/ AIDS and STDs compare
- To assess the extent of male involvement in sexual and reproductive health Matters.

HYPOTHESES

1) Significant difference in decision making of men and women regarding major household choirs and Reproductive Health.
2) Significant difference between men and women regarding gender wise preferences for children.
3) Significant difference between men and women in terms of knowledge regarding Family planning, STD/ HIV and Reproductive health.

4) A scope for Spousal Communication regarding children's education, fertility preferences, family planning and Reproductive health.
5) Significant scope and need for men's involvement in Reproductive Health.

METHODOLOGY

The methodological aspects of the study include the selection of the district, selection of revenue divisions, selection of mandals, selection of sample men and women respondents, sources of data, tools of data collection and tools of analysis, period of study and scheme of presentation.

Universe and sample

Anantapur district of the Rayalaseema region of Andhra Pradesh has been selected for the purpose of the present study which has been divided into three revenue divisions' i.e. Dharmavaram, Anantapur and Penugonda. Multi-stage random sampling method has been used for selection of the sample respondents. Accordingly, in the first stage, three revenue divisions have been considered for study. In the second stage, from each revenue division two mandals have been selected randomly. In the third stage, in each mandal two villages have been selected. The villages selected for the purpose of this study are R.B. Vanka, Pachapuram PC Pyapili, Chagallu, Ananda palyam, and Avinakunta. From each village twenty five men and women were selected. The entire sample was married. Care was taken that no two sample were from same family. Three hundred out of total households of 3,135 from six villages were selected as sample. The percentage of sample in the universe is nearly 10 per cent. Stratified sampling method

was used for selection of respondents. Structured interview schedules have been used to collect the primary data.

Sources of Data and Tools of Data Collection

The present study is based on both primary and secondary sources of data. Published books, journals, official records, government orders and other related material are the major source of secondary data. The primary data have been collected from the respondents through a well structured interview schedule which was pre-tested. And necessary changes have been made to suit the present study. The schedules were filled in with the help of the sample respondents through a face to face interview by the researcher. Focused discussions with the respondents were held to get their views on men's involvement in reproductive health.

TOOLS OF ANALYSIS

The data collected through schedules have been classified and tabulated into many tables for analysis purpose. Sample statistical tools like averages, percentages etc have been used to analyse the data.

Based on the data collected, certain conclusions were drawn and suggestions are presented in the concluding chapters.

The thesis is divided into **seven chapters** in the following order.

1st Chapter: Introduction, need for the study, objectives, methodology and review of literature.

2nd Chapter: Gender status in India.

3rd Chapter: Health conditions of women in India.

4th Chapter: Population and Family Planning Policies in India.

5th Chapter: Initiatives and Strategies for Men's involvement in India.

6th Chapter: Profile of the Respondents and impact study.

7th Chapter: Summary of Findings and Conclusions followed by Bibliography and Appendix.

REVIEW OF LITERATURE

A comprehensive review of literature is essential in any research endeavour. The main function of the review of literature is to make the researcher up to date with the research in the field of investigation and to assist in the delineation of the problem area. The main function of the review of literature is to determine the amount of work both theoretical and empirical that has already been done.

Studies done regarding Health seeking behaviour

A study was conducted in the service area of the Jawaharlal Institute Urban Health Centre (JIUHC), Kuruchikuppam - Pondicherry, attached to the Department of Preventive and Social Medicine, JIPMER. The study population was men within five years of married life, residing in the area. All couples who completed their family planning practised 'Tubectomy' as the permanent method of sterilisation.[42]

Some of the studies that have looked at health expenditure pattern show that more is spent per illness episode in men as compared to women, in all age groups or more number of men were treated as compared to women in the bottom expenditure groups.[43]

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[42] Bottero A. (1991). Consumption by semen loss in India and elsewhere. *Culture, Medicine and Psychiatry*, Vol. 15, pp.321-359.

[43] Duggal, R., Nandraj, S. and Vadair, A. (1995). "Health Expenditure Across States", Part-I & II, *Economic and Political Weekly*, Vol. 30(15 & 16), pp.834-844 and 901-908.

From one gynaecology clinic in northern Nigeria it is reported that three hundred young women a month are treated for the repair of vasico-vaginal fistulae, while in other areas the waiting list is said to be thousand women. A majority of the women, so handicapped are cast out by their husbands, with no support and often turn to prostitution or die a slow, difficult death. In the same area in Nigeria, it has been estimated that for every woman who died as a result of childbirth, about 15 suffered permanent handicaps.[44]

Abortion is widely resorted to and many women take recourse to unsafe abortions at the hands of untrained persons. Mortality in legal abortions that are performed therapeutically is estimated to be 2 per 1lakh procedures in industrialised countries and 6 per 1lakh in Developing Countries. But clandestine abortions give rise to very high mortality - 50 deaths per 1 lakh procedures in developed countries and about four hundred deaths per 1lakh procedures in developing countries. Doubts are expressed about the incidence of deaths in the developing countries and the figure of 4 hundred is feared to be a gross underestimate.[45]

Shelley Saha and Dr Sundari Ravindran made a critical review of selected studies from 1999-2000 named Gender gaps in Research on Health services in India. They have listed the unexposed issues as Gender equity in the Reproductive health system and called for many researches to come up understanding the gender relations.[46]

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[44] Malini, Karkal, 1996, Reproductive Rights and Reproductive Health of Women. : Studies in Social Demography. Edited by J.P.Singh. M.D.Publication Pvt Ltd, New Delhi.. ISBN 81-7533-070-8. Location: SNDT Churchgate, p.342

[45] Karkal, Malini, 1996, "Reproductive Health and Women: A Review of Literature", Radical Journal & Health,2 (1): 54-67.

[46] Shelley Saha and Dr Sundari Ravindran, Gender gaps in Research on Health services in India, A critical review of selected studies (1990- 2000),Published by CREA (Creating resources for empowerment in Action), New Delhi, p. 1

But for a lone study, which assessed the progress of the CNA approach to contraceptive services in nine Indian states, there is a major gap in information on this crucial area. This study concluded that there were some changes from centralised target setting to more locally determined targets, but contraceptive choices were still made by service providers on the basis of the number of children women had, and not by women themselves. There was no improvement in terms of access to and availability of Medical Termination of Pregnancy (MTP) services and in the best of scenarios, reproductive health services translated into sporadic camps screening for and treating Reproductive and Sexual Tract Infections. A couple of other studies comment mainly on the gaps -such as the neglect of adolescent sexual and reproductive heath needs, and the lack of integration of services for HIV/AIDS and maternal and child health and family planning.[47]

In case studies from Karnataka, ANMs reported that their work was tightly supervised whereas their male counterparts were rarely made accountable or evaluated. Again, male multipurpose workers had a higher status in the health delivery system and were seen as 'doctors', while ANMs were treated as mere birth attendants although they bear the entire burden of grass roots implementation of family planning services, child survival and safe motherhood initiatives.[48]

Silvina Ramos, Mariana Romero and Mónica Gogna from CEDES (Center for the Study of State and Society) Health, Economy and Society Department has developed several research projects focusing on the impact of health sector reform on the structure

[47] *Ibid*., p. 12.
[48] Shelley Saha and Dr Sundari Ravindran, Gender gaps in Research on Health services in India, A critical review of selected studies (1990- 2000),Published by CREA (Creating resources for empowerment in Action), New Delhi, p. 1.

and dynamics of the health system in Argentina as well as on the monitoring and evaluation of reproductive health policies and programs both at the federal and local levels.[49]

K.S.James, N. Krishnaji, G. Rama Padma of Centre for Economic and Social Studies are currently doing a large research study to understand the maternal health from different angles in Andhra Pradesh, India. Andhra Pradesh has undertaken far reaching reforms both in economic and social sectors. What impact it makes on maternal and reproductive health is the large question of this study. Many studies are undergoing as part of this research project.[50]

Gender and Health Equity Karnataka Case Study by Asha George, Gita Sen, Aditi Iyer Three partners (the Indian Institute of Management, Bangalore, Mahila Samakhya Karnataka and the Karnataka Department of Health and Family Welfare) are working together to improve health system functioning, with a focus on gender equity.[51]

This study described the natural history of depression in mothers who recently gave birth in a low-income country and to investigate the effect of risk factors, particularly related to infant gender bias, on the occurrence and outcome of depression.

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[49] Sundari Ravindran, Ranjani.K.Murthy; MIDS - Padmini Swaminathan., "Related initiatives and individuals - The initiative for sexual and reproductive rights in health reforms", Department of Reproductive Health and Research of the World Health Organization available at http://www.wits.ac.za/whp/rightsandreforms/list.htm

[50] *Ibid*.

[51] Vikram Patel, Merlyn Rodrigues and Nandita DeSouza (2002). "Gender, Poverty and Postnatal Depression: A Study of Mothers in Goa", India. *The American Journal of Psychiatry*, American Psychiatric Association, January, pp. 43-47.

The authors studied a group of pregnant mothers recruited during their third trimester of pregnancy from a district hospital in Goa, India. The mothers were interviewed at recruitment, 6–8 weeks, and 6 months after childbirth. Interview data included presence of antenatal and postnatal depression, obstetric history, economic and demographic characteristics, and gender-based variables (preference for male infant, presence of marital violence).

Depressive disorder was detected in 59 (23%) of the mothers at 6–8 weeks after childbirth; 78 per cent of these patients had had clinically substantial psychological morbidity during the antenatal period. More than one-half of the patients remained ill at 6 months after delivery. Economic deprivation and poor marital relationships were important risk factors for the occurrence and chronicity of depression. The gender of the infant was a determinant of postnatal depression; it modified the effect of other risk factors, such as marital violence and hunger. Depressed mothers were more disabled and were more likely to use health services than non depressed mothers. Maternal and infant health policies, a priority in low-income countries, must integrate maternal depression as a disorder of public health significance. Interventions should target mothers in the antenatal period and incorporate a strong gender-based component.[52]

Priya Nanda Jodi Jacobson from Centre for Health and Gender Equity Change is conducting three research studies on understanding the implications of health sector reforms on reproductive health and rights in India and Tanzania. The studies look at the policy environment in which reforms are taking place as well as the implementation of

[52] Vikram Patel, Merlyn Rodrigues and Nandita DeSouza., 2002, "Gender, Poverty, and Postnatal Depression: A Study of Mothers in Goa, India", The American Journal of Psychiatry© 2002, American Psychiatric Association, January: 43-47.

reforms from a reproductive health and rights perspective. The studies are prospective in nature and undertake a process analysis as reforms are still at early stages of implementation in these countries.[53]

Studies done regarding Reproductive Health

Traditional beliefs can undermine reproductive health. It was found that traditional beliefs about semen and sexuality led to reduced protection from STDs. Traditional beliefs about such matters as erectile dysfunction impeded reproductive health care. Concerns about sexual inadequacy among a minority of young men led to family violence and discouraged them from using contraception.[54]

The programme of action globally endorsed at the International Conference on Population and Development (ICPD) emphasised the need for equity in gender relations with a special focus on men's shared responsibility and active involvement to promote reproductive and sexual health.

In Orissa, eastern India, a study was undertaken in the coastal districts to inform condom social marketing programmes: a qualitative study preceded a population-based survey among urban and rural men. In rural Bangladesh, a population-based survey of STI prevalence was undertaken among men in the Matlab area. The aim of the research

[53] Sundari Ravindran, Ranjani, K. Murthy; MIDS - Padmini Swaminathan "Related initiatives and individuals - The initiative for sexual and reproductive rights in health reforms", Department of Reproductive Health and Research of the World Health Organization available at http://www.wits.ac.za/whp/rightsandreforms/list.html.

[54] UNFPA (1998). "Male involvement in reproductive health: incorporating gender throughout the life cycle", Technical Support Services System: Occasional Paper Series No.1, June , New York, USA, Chapter 1, p.2.

was to inform decision-making around provision of STI management and control programmes.[55]

Few studies, moreover, have compared the perspectives of women and their husbands on women's roles and the extent to which they have and should have a voice in their own lives. Rather, studies that have explored spousal convergence have focused on reproductive attitudes and preferences. The extent of spousal agreement reported in these studies varies. For example, a recent review of studies reporting attitudes of women and their husbands concerning reproductive health finds that with respect to fertility and family planning, the proportion of agreement between partners across a number of studies is in the range of 60-70 per cent. Another study found that spousal agreement on the desire for additional children in 26 Asian communities ranged from 70 per cent to 90 per cent.[56] Another study, conducted in Punjab Province, Pakistan, explores attitudes and perceptions of women and their husbands with regard to aspects of reproductive health and female autonomy and suggests considerable divergence in spousal perceptions of women's autonomy. Findings from most of these studies indicate that reproductive health interventions aimed at both partners in a couple may be more effective than the same interventions focusing on only one partner.

Vasectomy was not being practised by any of the husbands after completing their family. 46 per cent of the subjects felt the need for men's involvement in reproductive

[55] National AIDS Control Organisation (1998). "Country Scenario 1997-1998", Government of India, Ministry of Health and Family Welfare, New Delhi.

[56] Shireen J. Jejeebhoy (2002). "Convergence and divergence in Spouses' perspectives on women's autonomy in Rural India: Studies in Family Planning", Questia News Letter Questia Media, New Delhi, Vol. 33, December, p.299.

health. Studies have been published indicating that men have stressed the need to improve the acceptance of Family Planning methods for males by providing knowledge and information through sources such as radio, television, door to door campaigning and interpersonal communication. This study conducted at the Urban Health Centre - Kuruchikuppam, attached to the Department of Preventive & Social Medicine - JIPMER, justifies the 'Need for involvement of Men in Reproductive Health'.[57]

The reproductive health component among the Scheduled tribes, which constitutes about 84.3 5 million, i.e. 8.2 per cent of the India's population remain greatly neglected through out the country. The undivided Madhya Pradesh accommodates the 6 largest share (23.7%) of the Scheduled tribe population of the country with poor quality of life and needs special packages for its all round development. A look into the selected Maternal and Child health parameters of these Scheduled tribes of undivided Madhya Pradesh from National Family Health Survey (NFHS2) data projects how grave the situation is.

NFHS data reveals that in Madhya Pradesh about 20 per cent of tribal women received antenatal check-ups from trained doctors and 56 per cent does not receive any check up during their pregnancy. The tribal fertility is still at higher side with a total fertility rate (TFR) of 3.69 exceed the same for state (3.31). The higher fertility among them can also be accounted for the greater desire for children among the husbands with a strong preference for male child. The current contraceptive prevalence rate (CPR) among

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[57] Rajesh Reddy, S., Premarajan, K.C., Narayan, K.A. & Akshaya Kumar Mishra (2003). "Rapid Appraisal of Knowledge, Attitude and Practices related to Family planning methods among men with in 5 years of married life", *Indian Journal of Preventive and Social Medicine,* Vol. 34, No.1,& 2, Jan-June, p.67.

them is 31 per cent for any modern methods and points to the poor participation of male in family planning (0.4% for condom user and 2% for male sterilisation).

One of the studies provides important information about male reproductive health problems in a sample of men in rural West Bengal, India. The response of the men and the fact that nearly all attenders were willing to undergo a clinical examination is encouraging, and emphasises the possibilities for future research. The high level of reproductive health problems identified on clinical examination, but not reported in interviews, plus the low levels of condom use illustrate the need for reproductive health interventions with such groups.[58]

In the study structured interviews were carried out with 120 men attending a reproductive health check-up in a village in rural West Bengal, India. General information, details of family planning methods used and data on reproductive health complaints were collected. Clinical examinations were also carried out. Socio-demographic characteristics were compared for men with and without reproductive health and urinary complaints.

Three quarters of the married men were using contraception, but the majority stated that their wives were responsible for it. The most common reproductive health complaint was urinary problems; 28 per cent had burning on urination, and 22 per cent reported frequent and/or difficult urination. There were few social or demographic differences between men with and without problems. Seventeen per cent of the men had

[58] Kate M Dunn, Susmitha Das and Rumeli Das (2004). "Male Reproductive Health, A village based study of camp attenders in rural India", Reproductive Health, Dunn *et al*., Licensee BioMed Central Ltd., Vol. 1, p. 7.

clinically diagnosed reproductive health problems, the most common being urethral discharge. None of the men with diagnosed problems were using condoms.[59]

A study of men's perceptions of sexual problems in a Mumbai slum community found that men were most concerned with sexual weakness, itching around genital areas, burning sensation during urination, early ejaculation, wounds on the genitals, and white discharge. Issues raised by men in Pune, India, include masturbation, consequences of loss of semen, menstruation, pregnancy, and AIDS.[60]

A community-based cross-sectional study of RTIs was conducted in 1996-1997 among married women 16-22 years of age in Tamil Nadu, India. The women were questioned about symptoms, received pelvic and speculum examinations and provided samples for laboratory tests. Qualitative and quantitative data on treatment-seeking behaviour were collected. Fifty-three per cent of women reported gynaecologic symptoms, 38 per cent had laboratory findings of RTIs and 14 per cent had clinically diagnosed pelvic inflammatory disease or cervicitis. According to laboratory diagnoses, 15 per cent had sexually transmitted infections and 28 per cent had endogenous infections. Multivariate analysis found that women who worked as agricultural labourers had an elevated likelihood of having a sexually transmitted infection, as did those married five or more years. Two-thirds of symptomatic women had not sought any treatment; the

[59] *Ibid*.
[60] Kate M Dunn, Susmitha Das and Rumeli Das (2004). "Male Reproductive Health, A village based study of camp attenders in rural India", Reproductive Health, Dunn *et al*., Licensee BioMed Central Ltd., Vol. 1, p. 7.

reasons cited were absence of a female provider in the nearby health care centre, lack of privacy, distance from home, cost and a perception that their symptoms were normal.[61]

Young married women in this rural Indian community have a high prevalence of RTIs but seldom seek treatment. Education and outreach are needed to reduce the stigma, embarrassment and lack of knowledge related to RTIs. The low social status of women, especially young women, appears to be a significant influence on their low rates of treatment for these conditions.[62]

From 1999 to 2006, the International Center for Research on Women (ICRW) collaborated with partners in India on multi-site intervention studies of issues related to adolescent and youth reproductive health (RH) in India. These partners included the Christian Medical College, Vellore (CMC), the Institute for Health Management, Pachod (IHMP), Swaasthya, KEM Hospital Research Centre, and the Foundation for Research in Health Systems (FRHS).[63]

All 5 studies involved men and boys in the interventions to varying degrees, and sought to understand and address barriers to their participation. Efforts included engaging men as community-level educators; involving fathers in designing life skills programmes; encouraging young boys to develop a sense of ownership for programme activities designed for them; and finding ways to increase and enhance husbands' participation in

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[61] Sulochana Abraham , Valentina George, M.N.R. Jayapaul , Renu John , Abraham Joseph , Kathleen M. Kurz , M.K. Lalitha , Jasmin Helen Prasad & Nandini Shetty (2005). "Reproductive tract infections among young married women in Tamilnadu, India", *International Family Planning Perspectives*. Washington DC, Vol. 31, Issue 2, p.73.

[62] *Ibid.*

[63] Ravi, K., Verma, G., Rangaiyan, S.*et al*., "Cultural perceptions and categorisation of male sexual health problems by practitioners and men in a Mumbai slum population". Available at www.hsph.harvard.edu/Organizations/healthnet/SAsia/suchana/0804/rh05 2.html.

RH care for themselves and their wives. Results were organised into three categories: understanding men's and boys' experiences with their own health and sexuality, involving men in women's reproductive health and engaging couple dialogue for improving the RH of both men and women.[64]

The study measured couple dialogue on RH issues by determining whether information was presumably passed on from a spouse who attended a session to the spouse who did not attend. It found that several topics yielded substantial increases in knowledge, including: limiting family size through vasectomies;

- medical advice an acceptable reason for an induced abortion; and female sex of the fetus not an acceptable reason for induced abortion. Wives' knowledge also increased on: avoiding work during pregnancy; sexually transmitted diseases (STIs) detectable through signs and symptoms; and HIV and AIDS and other STIs avoidable with condoms. There was one important increase in husbands' awareness: fewer men reported thinking that infertility problems emanated only from women. Another finding from the study was that men preferred a more didactic method of learning as compared to the dynamic, participatory methods (e.g., games and songs) found useful with women.[65]

- In Vellore district (Tamil Nadu), CMC is testing the effectiveness of two approaches to diagnose and treat RTIs among rural, young married women and their partners. Cure rates for women are compromised because male partners are not accessing

[64] Intervention Studies on Youth Reproductive Health in India: Findings about Men's Involvement Placed on the Communication Initiative site (2005). February 17.
[65] *Ibid*.

treatment to the same degree, in spite of medications and referrals being made available to them. Six focus group discussions with 40 unmarried and married men aged 23-30 revealed that men know about and support prevention of and care for STIs and HIV/AIDS. However, they reported feeling shy, embarrassed, and ashamed to seek treatment for RTIs, which can be associated with having had extramarital sex or sex with a commercial sex worker. Qualitative data from the study suggest that husbands took a diagnosis more seriously and would be more willing to get treated if the woman's infection was severe and if a medical professional directly encouraged him to do so. Also, though women were reluctant to give medicine for STIs to their husbands, most symptomatic women discussed their diagnosis with their partners and most reported that their husbands encouraged them to receive treatment.[66]

Young men express concern about sexuality, while couples request information about fertility concerns

In Ahmednagar (Maharashtra), FRHS formed male youth groups and community interactive health education sessions as social mobilisation components of its intervention to improve the RH of young married girls. The male youth groups, made up of males up to age 35, became active social mobilisers, voicing issues about their and their wives' sexual and reproductive health. In health education sessions, youth groups chose topics by consensus, including HIV/AIDS transmission and prevention, STI signs and symptoms, sexual performance, infertility and family planning.

Young men expressed anxiety about their sexuality and sexual performance, so sessions dealt at length with questions and misconceptions about erection, desire,

[66] *Ibid.*

impotence, size and shape of the penis, and effects of promiscuous sexual behaviour. Similar to male youth groups, in community health education sessions, 110 young couples requested more information on a concern of their own: infertility. In response, FRHS arranged for a sexuality counsellor to talk with couples about their fertility concerns. Qualitative data from 79 couples suggests that women were most often blamed for a couples' infertility and could suffer social consequences as a result, including: taunting; not being invited to important social occasions; not accepted into marital families and communities as a legitimate wife; disapproval in the form of extra work, denial of food and violence; and attempts at a second marriage by the husband. Men also indicated experiencing anxiety about infertility, even if the social consequences for them are less severe. Despite both partners' concerns, the study did not indicate that couples were discussing their infertility.[67]

Further, the survey also projects a very pitiable situation in which 43 per cent of currently married women report at least one reproductive health problem related to vaginal discharge, urination, or intercourse that could be symptomatic of a more serious reproductive tract infection, the majority of them bear the problem silently without seeking advice or treatment. Further, infant mortality is still very high (101) among the Scheduled tribe population. Among them, 1 in every 10 children born died within the first year of life, and 1 in every 6 children died before reaching age five. However, these are only few parameters, the information for which is generated from ever-married females in the age group 13 to 49 years.

However, limitation of the NFHS data is that it lacks information on men's reproductive health. However, no proper statistics on the extent of Scheduled tribe

[67] *Ibid.*

male's involvement in reproductive health and the problems they suffered are available. Hence, in addition to any programmatic effort to involve male in reproductive health, an understanding of level of knowledge, attitude and extent of participation of Scheduled tribe men on different aspects of reproductive health will help the planners to correct the deficiencies by bringing about a qualitative change among men in this regard by educating them with suitable IEC strategy.[68]

D. Ramu, Director S. Vanaja, Project Officer, Centre for Awareness and Rural Education (CARE) are currently working for the Reproductive health issues of adolescent girls in the rural areas. They did RTI/STI intervention among adolescent girls in 15 villages initially through awareness creation; screening camps and follow up activities and now we have extended this to the women also. They plan to take up a programme to educate the rural women on reproductive health rights and to work for lobbying to safeguard the reproductive health rights of women.[69]

Studies about male involvement in Reproductive health

The involvement of men, one of the recommended courses of action in Cairo Conference and at the national front has been assessed in a study (1991) conducted as both important and urgent in women's health initiatives. For one, almost all men (9 of every 10) are household heads who exert considerable influence on familial affairs impacting on women's health. For another, men have greater propensities to bring

[68] Dr Kalyan B Saha (2006). "Improving male involvement in reproductive health :lessons learnt from tribal population of Madhya Pradesh", ,RMRCT, Vol 3, No.2, Oct., p.1.

[69] Sundari Ravindran, Ranjani. K. Murthy; MIDS - Padmini Swaminathan "Related initiatives and individuals - The initiative for sexual and reproductive rights in health reforms", Department of Reproductive Health and Research of the World Health Organisation available at http://www.wits.ac.za/whp/rightsandreforms/list.htm

problems to women, more specifically to their wives, because they desire greater sex, they multiple sexual partners, and they are the sources of violence.[70]

In domestic violence, male participation was considered in about a third of 20 action projects, and the only two documented studies on the topic. All three STD/AIDS women-focused interventions were described to have taken into account men's involvement. The men involved were not necessarily the marital partners of female participants. Some were women's co-residents (from varying economic and occupational backgrounds) residing in the communities where the programs or projects were being carried out. In STD/AIDS interventions, men, side from receiving educational materials, were motivated to use condoms or were users of condoms. In the majority of the other interventions, where men were the sole target group or co-target group of women, the patterns of their participation resembled many of those that characterised male participation in women's health projects.[71]

One study (1997) examined male involvement in family planning practice and decision making in one Indian family over five generations. Data were collected from 152 living family members: information about an additional 26 members who were deceased or unavailable for interview were gathered using interviews with their children and siblings. The majority of the contraception used in this family consisted of male methods (condoms, vasectomy, natural family planning), particularly among older generations who had limited access to methods for women. Many men in the family

[70] Bottero A. (1991). "Consumption by semen loss in India and elsewhere", Culture, Medicine and Psychiatry, 15, pp.321-359.
[71] *Ibid,* p. 360.

reported being motivated to use male methods by external factors, such as desire for the improved economic status of a smaller family.[72]

In a survey conducted in Agra, a probing on why men prefer tubectomy over vasectomy revealed four concerns which were frequently mentioned by male respondents: (a) vasectomy makes men weak and less productive which they cannot afford being the main bread-earner of their families. Many women also felt the same way; (b) vasectomy demands rest for several days which again males cannot afford, particularly if they have to earn their living on a day-to-day basis; (c) women do not do hard work, they live in home and hence can take rest; and (d) tubectomy is easier than vasectomy and does not require much rest. Yet another important concern which was shared by majority of the males was failure of vasectomy and its social consequences for the couples.

In general, four suggestions for reintroducing vasectomy were made: (a) provision of an attractive incentive; (b) aggressive educational campaign; (c) detailed and focussed counselling of men explaining both advantages and disadvantages of the method; and (d) increased availability of operation facilities.[73]

A publication of UNFPA (1995) lists the following reasons for the growing importance of male-involvement initiatives in family planning:

1. The advent of the AIDS epidemic has spurred intense interest in condom promotion.

[72] Karra, M.V. *et al*. (1997). "Male involvement in family planning: a case study spanning five generations of a South Indian family", *Studies in Family Planning*, Vol. 28(1), pp.24–34.
[73] Khan, M.E., Bella C. Patel (1997). "Male involvement in Family Planning", A KABP study of Agra District, India, Final Report, *Population Council*, June, p 10.

2. Men are more favourable to the general principle of family planning than has been assumed.
3. Male support affects both the adoption and the correct use of female contraceptives.
4. Male-involvement programs can be cost-effective if they are highly focussed and offer male contraceptive methods directly or by referral.
5. Men's role in the abuse of reproductive rights and sexual violence directed towards female partners and relatives should no longer be ignored, and
6. The international consensus reached at ICPD has created a momentum for action. One major difference between the concern for increasing male participation in family planning till recently (late eighties) and now is the conceptual shift in the objectives itself.[74]

Earlier, the main concern for increasing male participation in family planning was increasing contraceptive use and achieving demographic goals. In contrast, the Cairo declaration demands men's participation in family planning and reproductive health in terms of gender equality and fulfilling various reproductive responsibilities.[75]

Available studies show that in many developing countries males often dominate in taking important decisions in the family, including reproduction, family size and contraceptive use. Male-involvement not only helps in accepting a contraceptive, but also in its effective use and continuation. On the other hand, even if the wife wants to use contraceptive, she may not be able to use it or may be forced to discontinue the method, if the husband disapproves of contraception.[76]

[74] *Ibid.*
[75] *Ibid.*
[76] *Ibid.*

The focus on men does not mean that a gender approach is not used. Conversely, the emphasis on women in much of the gender literature has left male perspectives as the missing link to a true gender approach. Far from arguing that the focus should be on men and women separately, we argue for the need to base our strategies, be they oriented to men or to women, on the analysis of gender interactions and needs. This is meant to help strengthen a component of a broader and more comprehensive gender approach.[77]

Husbands ignored women's health care during pregnancy except for appreciating the need for a nutritious diet. While they advised women to reduce their workload, they generally did nothing to help, except in some cases where they assisted with household chores. Childbirth was seen as women's concern, and men were generally unaware of any problems.[78]

A study was conducted in Uttar Pradesh, India on husbands' reproductive health knowledge, attitudes, and behaviour: The Safe Motherhood Conference held in Nairobi in 1987 led to a wave of research on maternal mortality, and significant advances have been made since then in documenting its levels and causes around the world. Attention is now focused on the need for broadening the concept of women's health beyond the limits of maternity-related death and morbidity. Realigning the focus of research objectives on women's health to a notion more general than pregnancy and childbirth was one of the major agenda items at the International Conference on Population and Development (ICPD) held in Cairo in 1994 (United Nations, 1995) and the impetus behind the recent

[77] *Ibid*.
[78] UNFPA (1998). "Male involvement in reproductive health: incorporating gender throughout the life cycle", Technical Support Services System: Occasional Paper Series No.1, June , New York, USA, Chapter 1, p.2.

body of work on female reproductive morbidity provide an extensive review. However, in an effort to rectify the dearth of information on the health and general well-being of women, men's concerns with and connection to reproductive health issues have largely been bypassed.[79]

The biological link between male and female reproductive health status is obvious. Less apparent, but equally important, is the impact of men's knowledge, attitudes, and behaviour on women's health. In regions where underlying socio-economic structures such as kinship and marriage allocate power and authority primarily to men, women are dependent on men for access to food, health services, and other things that contribute positively to health status. Although the causal pathways of influence have been difficult to identify, studies from all over the world have shown that maternal and child health outcomes tend to be poor in areas where female social status is low. The recent call for a gender-based program of research and services is based on an increasing awareness of the interdependence of female and male health status: If the needs of men with respect to reproductive health education and services are not considered, progress toward better health for people of both sexes will be hampered. A gender-based program of research that takes both female and male roles into account will benefit the social and physical health of the entire family and contribute to the empowerment of women.[80]

In Family Welfare Education and Services (FWES) project villages, girls' enrolment in schools has increased and sex ratios for newborns have not changed, unlike

[79] Shelah S. Bloom, Kaushalendra K. Singh and Amy Ong Tsui (1998). "Husbands' reproductive knowledge, attitudes and behaviour in UP, India", *Studies in Family Planning*. Vol.29. Issue 4, p.388.
[80] *Ibid*.

neighboring 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.[81]

If men are brought into a wide range of reproductive health services in such a way that they are supported as equal partners and responsible parents, as well as clients in their own right, better outcomes are expected in reproductive health indicators such as contraception acceptance and continuation, safer sexual behaviours, use of reproductive health services, and reduction in reproductive morbidity and mortality.[82]

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 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.[83]

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[81] Sharma, Vinit and Anuragini Sharma (2000). "Encouraging the Involvement of Males in the Family", p.5.
[82] The State of World Population by United Nations Population Fund (2000). "Lessons from India Men, Reproductive Rights and Gender Equality", Chapter 4, p. 7.
[83] The State of World Population by United Nations Population Fund (2000). "Lessons from India Men, Reproductive Rights and Gender Equality", Chapter 4, p 6.

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. CHETNA now concentrates on involving men in early childhood care, including teaching them about nutrition and growth monitoring; teaching adolescent boys about sexual and reproductive health; and using trained male health workers to motivate men to take an interest in women's health.[84]

Men and women often perceive reproductive health issues differently. Among married adolescent couples interviewed in one of the studies,[85] the men described the positive effects of marriage on their daily lives, and indicated they believed their wives shared their opinion. Wives had a more mixed assessment of marriage, as they adjusted to the burden of their multiple responsibilities.

Men accompanied their wives to their first check-ups to confirm a pregnancy, but wives did not expect or want further visits with their husbands. Clinic workers seeking to shield other women did not encourage them.[86]

Programmes to involve men should be designed to address three major goals: (1) Improve sexual and reproductive health of men and women, (2) generate men's support for women's actions related to reproduction and respect for women's reproductive and sexual rights, and (3) promote responsible and healthy reproductive and sexual behaviour

[84] *Ibid*.
[85] Verma, Ravi K. *et al*. (2000). "Men's Sexual Health Problems in a Mumbai Slum Population", p.4.
[86] The State of World Population by United Nations Population Fund (2000). Lessons from India Men, Reproductive Rights and Gender Equality, Chapter 4: p 6.

in young men and boys. Gender inequality is a major barrier that must be overcome if these goals are to be met. Improving the reproductive well-being of women and men requires freeing them both from restricted gender roles.[87]

In 2001, The Reproductive Health Research Unit of Witwatersrand University, in partnership with the FRONTIERS program of Population Council and the Kwazulu – Natal(Deliveries) Department of Health began a three – year operations research study, to incorporate men in their partners' maternity care, in order to improve couple's reproductive health and pregnancy outcomes.[88]

The study showed that it was indeed acceptable and feasible to involve men in reproductive health care of their partners. Both men and women were interested in involving men during Maternity care. However there remain a number of health service challenges that need to be addressed with in the South African context before Maternity services become more male friendly.[89]

As part of an extensive qualitative study identifying patterns of sexual behaviour, the cultural perceptions of men's sexual health problems were explored using in-depth interviews with key informants and case study informants. Men in this study did not associate *dhatu padiba* (White Discharge) with sexual transmission, but another concern sometimes mentioned was *parishra-poda*, denoting a burning sensation during urination. Both conditions are believed to be caused by *peta garam* (heat in the stomach) as a result

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[87] Pachauri (2001). "Male involvement in reproductive health care", *Journal of Indian Medical Association. South and East Asia*, Population Council, New Delhi, published by PUBMED. March, Vol.99(3), p.138.

[88] Saiqa Mullick, Busi Kunene and Monika Wanjiru (2001). "RHRU, agenda paper on Involving men in Maternal Care, Health Service Delivery Issues", South Africa, p.1.

[89] *Ibid.*

of excessive heat and cultural hot/cold belief systems underlie the physiology of leaking semen.[90]

However, since penile discharge together with painful urination form the syndromic diagnosis for gonorrhea and Chlamydia, there is potential for confounding semen loss with pus discharge, if clinical diagnosis is based on reports rather than the actual observation of a discharge. It is important to stress that the white discharge in *dhatu padiba* is usually not directly observed. Other studies confirm that most often the diagnosis is made indirectly on the basis of a set of complaints about weakness and persistent fatigue. Semen loss is thus implied rather than observed.

In pursuance of this vision, the reproductive health strategy for the African region was developed in 1998. The strategy is aimed at assisting member states and partners to identify priorities and plan their programmes and interventions at various levels, particularly at the district level. Male involvement and participation is one of the strategic directions of the reproductive health strategy for the African region. The opportunities and challenges for the involvement of men in reproductive health programmes in the African region are described and the future perspectives highlighted.[91]

A recent comprehensive review of the published epidemiology of STIs in India found that data on STI prevalence in men are lacking, especially men in the 'general

[90] Dr Sarah Hawkes and Dr Martine Collumbien (2001). "The sexual health of men in India and Bangladesh: what are men's concerns? Programming for male involvement in reproductive health", Report of the meeting of WHO Regional Advisers in Reproductive Health, September, p.8.

[91] Andrew Kosia (2001). "Programming for male involvement in reproductive health", Report of the meeting of WHO Regional Advisers in Reproductive Health, Washington DC, USA September, p 95.

population'. The results highlight how little is known about the 'true' population-based burden of biomedically defined STIs in men in India and Bangladesh.[92]

Effective management of men with STIs can only be assured if men present to trained health providers as soon after the onset of symptoms as possible. Surveys in Bangladesh and India show that most people with STI symptoms seek care in the unregulated (and predominantly untrained) private sector. The National AIDS Control Organisation in India, for example, estimates that only 5-10 per cent of patients with STIs present to public sector care. This is true not just for STIs, but for a wide range of curative services, and it is not only the economically wealthy who seek private medical care; the poor choose private providers for a variety of reasons as well.

Global: Men in Maternity, the global study, undertaken by Frontiers researchers in India and South Africa, seeks to involve male partners in health services during the antenatal period, with the goal of improving postpartum family planning care and treatment of sexually transmitted infections (STIs). At the same time the study aims to develop an acceptable expanded antenatal and postpartum care program to include both men and women.[93]

In India, the study surveyed couples attending the antenatal clinic at the Employees' State Insurance Corporation (ESIC), the largest social insurance program in India catering to industrial workers in urban and semi urban areas that provides health care through hospitals and clinics in New Delhi. The study sought to determine the

[92] Hawkes, S. and Santhya, K.G. (2002). "Diverse realities: understanding HIV and STIs in India. Sexually Transmitted Infections", 78, suppl. 1, pp.531-539.
[93] Anurag *et al*. (2002). "Preliminary findings of Men in Maternity: Population control research data", New Delhi, India, July, p.2.

feasibility, acceptability, and cost-effectiveness of incorporating men as active partners in their wives' antenatal and postnatal care. The effect of shifting the health care sector's focus from women exclusively to couples was investigated through measurement of selected male and female reproductive health and infant health indicators.[94]

Results suggest that involving men in the antenatal care of their partners in India is both acceptable and affordable for both clients and providers. Nearly three-quarters of men in the study joined their wives during antenatal visits and postnatal consultations. The results also show that it is feasible to integrate other services to serve men and women's reproductive health needs. For example, male physicians trained in STIs/HIV are now managing not only antenatal clients' husbands with complaints, but also other dispensary clients who present with RTI/STI symptoms.[95]

A study was conducted in the Alwar district of Rajasthan since National Family Health survey, 1992-93 showed low level of male participation in Family planning in Rajasthan. Out of 32 per cent couples who were using a method of family planning only 4.7 per cent were using male dependant methods. Three villages having either a PHC/ sub-centre with a low use of male contraceptive methods were selected using purposive sampling. Women reported to be married at very early age between 8-9 years. Female sterilisation was the only one family planning method followed. Very few of them

[94] *Ibid*., p. 3.
[95] *Ibid*., p. 26.

reported IUD and oral pill usage. Condom use was low. Only one family reported male sterilisation.[96]

Women reported that they hardly discussed about family size and contraceptive use with their husbands. None of the instances they visited doctor for any reproductive health problem. Only traditional treatment methods were followed. Men were not involved in child rearing activities.

The study reveals that women want men to be involved in reproductive health and that male methods are acceptable to them so long as they are safe. Not only but women should also be educated about male methods, which are safe and simple compared to female methods of sterilisation. This signals the need for couple counselling.[97]

A study was conducted in Central India about men's involvement in reproductive health among Khairwar tribes. The objective of the study was to reach sexually active married males in disadvantaged tribal group for understanding their ideas in reproductive and sexual health, popularity of Government health services among them and to identify the issues for developing a broad communication strategy for better male participation in the same. The survey was conducted among 260 males and broadly the issues covered are knowledge, suffering and treatment seeking behaviour pertaining to reproductive tract infections, knowledge of HIV/AIDS, knowledge and utilisation of family planning and antenatal care services, and their perception of sexual problems.[98]

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[96] Abhilasha Sharma (2003). "Male Involvement in Women Reproductive Health", Paper presented at the Millennium Conference on Population, Development and Environmental Nexus and XXIII Annual Conference of the Indian Association for the study of Population held in New Delhi, February 14–16, 2000, Vol. 49, No.1, pp.5-6.

[97] *Ibid*.
[98] *Ibid*.

The study highlighted that Khairwar men have no proper knowledge of reproductive health matters. Over and above Government health services are less popular among them leading to under-utilisation of the same. The study points to the fact that it is the high time to generate a demand among male, for reproductive health services both for their own problems and also for their partners by using a need based IEC strategy. Also it suggests strengthening health delivery system by incorporating male oriented reproductive health services in remote areas of their habitation.[99]

In India, men are often the primary decision makers regarding women's health care, but they remain poorly informed about women's health. Between 2000 and 2003, FRONTIERS and the Employee's State Insurance Corporation (ESIC), a government-affiliated insurance agency for low-income workers, conducted a study on the effect of men's involvement in their partner's pregnancy.

The study assessed the effect of men's involvement during antenatal and postnatal care on the couple's use of family planning and STI prevention. The intervention took place at six ESIC clinics in New Delhi, with three clinics serving as experimental sites and three as control sites. Twelve auxiliary nurse-midwives (ANMs) and 12 doctors were trained to provide couple and individual counselling.[100]

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[99] Kalyan B. Saha, Neeru Singh, D.C. Jain, Uma C. Saha. "Men's Involvement in Reproductive Health: A study among the Khairwar Tribe of Central India", p.10.

[100] Varkey, Leila Caleb, Anurag Mishra, Anjana Das, Emma Ottolenghi, Dale Huntington, Susan Adamchak, and M.E. Khan (2004). "Involving men in maternity care in India", Frontiers in Reproductive Health Program, Population Council, New Delhi, p.2.

An intervention during prenatal consultations to increase men's involvement in their partners' maternal care increased couples' discussion and use of contraception and improved knowledge about pregnancy and family planning. The intervention is being expanded within the context of India's insurance scheme for industrial workers' families to hospitals and additional health centres.[101]

Collaborators tested various communication-based interventions in an effort to understand men's involvement in young women's RH - as well as men's own needs. The activities and strategies used interpersonal, face-to-face channels in an effort to stimulate dialogue between partners, motivate men and women to take active roles in their own and their partners' RH, and change RH-seeking behaviour for better overall health. The various roles that gender plays in RH - and strategies for cultivating a sensitivity to that role-figured prominently in this research. The approach involved finding ways to increase the participation of *each* of those actors who exercise influence over adolescent girls lives, such as male partners and fathers, so that they became supportive allies of the girls.[102]

Fathers are compelling advocates for skills their daughters' need to ensure quality of life after marriage

In Maharashtra, IHMP conducts an intensive one-year life skills course for unmarried, out-of-school adolescent girls (10-18 years of age) that is designed to improve their self-esteem and literacy, and to delay marriage. IHMP worked closely with their fathers and mothers in designing the course, conducting monthly meetings to discuss the

[101] *Ibid*., p. 3.
[102] Intervention Studies on Youth Reproductive Health in India: Findings about Men's Involvement Placed on the Communication Initiative site (2005).

girls' progress. IHMP found that both fathers and mothers welcomed the programme and participated fully. However, whereas mothers left the details of curriculum development to the "experts" among IHMP's staff, "fathers forcefully appealed for life skills modules they felt their daughters would need in married life, such as a working knowledge of child upbringing, home management, money management, and agriculture, as well as sexual and reproductive health.[103]

Husbands are knowledgeable and feel responsible for their wives' maternal care, but they often do not participate in that care despite their interest. Through interviews with 972 husbands in Ahmednagar district (Maharashtra), FRHS found that more than 75 per cent are aware of their adolescent wives' need for antenatal care. Fewer knew about delivery and postnatal care, which is likely to be related to the local custom of the wife delivering away from the husband at her mother's house, and staying at the natal home during the postnatal period. Although most husbands also feel responsible for, and indicate that they want to participate in, maternal care, only about half accompanied their wives for routine care. Sex and gender norms dissuading husbands from participating included: the belief that maternity is a 'woman's affair', decisions about maternal care were usually made by mothers-in-law or mothers, and the practice at health centres in which husbands are often made to wait outside while their wives receive care.[104]

Community-level educators successfully engage men in RH when they adopt new approaches

In an effort to reach young, married couples *as* couples in a rural part of Pune district (Maharashtra), KEM selected and trained 5 men and 6 women from the project

[103] *Ibid*., p.10.

villages to serve as volunteer community level educators (CLEs). CLEs worked as male-female pairs to lead RH education sessions, provide referrals to services, and conduct sexuality counseling sessions. In 3 cases, the CLE pairs were young, married couples themselves. This proved effective, as newly married husbands and wives felt freer to talk about sexual and RH concerns with someone they knew was in a similar situation. It was also more acceptable within the community for a married couple - the CLEs - to talk about RH matters.[105]

Fathers supported the inclusion of a comprehensive sexuality module, but requested that it be reserved for older girls. Fathers also suggested acceptable venues for the course within the villages, the duration and timing of the course, as well as the profile of the teachers. Finally, 70 per cent of fathers kept track of the progress of the course by asking daughters what they were learning from their life skills classes. It was apparent throughout the course that fathers held their daughters' interests at heart, even though they would be leaving their parental homes for marital homes in the next few years.[106]

Popular figures in the local community can generate interest among unmarried, adolescent boys

To engage adolescent boys in the Naglamachi slum (Delhi), Swaasthya, an Indian NGO employed a popular male teacher from the community to conduct group information, education, and communication (IEC) sessions specifically for boys. This well-liked teacher drew the interest of the boys and the sessions were well attended. However, male participation in the programme proved hard to sustain when the teacher

[104] *Ibid.*
[105] *Ibid.*, p. 15.

left the programme and could not be replaced. When Swaasthya sought outreach workers to lead the sessions, it found that boys were not comfortable with female outreach workers, and male outreach workers were rare due to low wages in such social-sector jobs.

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[106] *Ibid.*