Men as Supportive Partners in Reproductive Health

MOVING FROM RHETORIC TO REALITY

Edited by
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While the need to involve men in reproductive health is now beginning to be articulated, translating this need into policies and programs is hampered by lack of information on the issues. The Population Council - South and East Asia office's program on **Enhancing Male Responsibility in Reproductive and Sexual Health** in India was designed to bridge this gap by collating such information and disseminating it to concerned audiences. The guiding principle of the project has been the belief that if men are brought into a wide range of reproductive health services as supportive and equal partners, as well as clients in their own right, better reproductive health outcomes would be observed both among women and men.

The project activities included documentation of research outcomes and programs undertaken by nongovernmental organizations, publications, and organization of several national workshops for the key constituencies including those at the policy level.

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This book builds on presentations and discussions of the Workshop on “Men as Supportive Partners in Reproductive and Sexual Health” held in Kathmandu, Nepal in 1998. Our foremost thanks go to those participants who painstakingly documented their experiences, ‘the most painful part’ as some nongovernmental organizations put it. Without their enthusiastic response, there would have been no publication of this nature.

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Foreword

The rhetoric of male involvement has now entered the vocabulary of many individuals and organizations concerned with reproductive health policies and programs. Experiential learning and research that document improved reproductive health outcomes are, therefore, important if this rhetoric is to be translated into policies and programs. There is a need to illustrate how this can be done at the ground level and to demonstrate why it is important for men to be supportive of women's reproductive health and choice. This publication takes a step in this direction by examining the current state of the art in India.

By analyzing the experiences of nongovernmental organizations across regions and states within India, the authors discuss several important concerns that should inform the discourse on male partnership, including: Does involving men mean encroaching on women's domain? How can men be involved without undermining the precarious rights of women to control their own bodies and make their own decisions? What are viable and acceptable entry points for involving men in efforts to prevent unwanted pregnancy, promote safe motherhood, improve child health and survival, and prevent sexually transmitted infections? How can lessons learned from successful microlevel experiments be scaled up within the mainstream of reproductive health care delivery?

This publication underscores that the previous views of reaching men as contraceptive users and removing them as impediments to women's efforts to control fertility are far too limited. The argument is not whether men and women should use family planning, but rather the extent to which men can become supportive of women's reproductive and sexual rights and actively take part in responsible and healthy reproductive behavior.

Applied research is urgently needed in order to learn how to stimulate and support positive and healthy sexual partnerships between women and men. We must demonstrate that contraceptive safety and continuation, safer sexual behaviors, use of reproductive health services, reduction in morbidity and mortality, and other health outcomes can be improved through the positive involvement of men as supportive partners and responsible parents. This publication provides a wealth of information on male partnership issues. We hope that it will facilitate further discourse, research, and interventions in this important but, as yet, nascent field of work.

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Introduction

Men's attitudes, behavior, and the general level of inequality between the sexes in terms of their intimate behavior and social relationships affect women's ability to exercise choice and attain positive sexual and reproductive health outcomes. Male dominance—physically, socially, and, most notably, in sexual relationships—can put women at risk of unwanted sexual encounters, pregnancy, and infection. Better, more open and egalitarian communication between women and men, and mutually supportive reproductive health behavior are not only necessary to the achievement of widely held social goals (expounded upon at the 1994 International Conference on Population and Development [ICPD] held in Cairo, Egypt and the 1995 United Nations Fourth World Conference on Women, held in Beijing, China), but lay a practical foundation for improvement in women's reproductive health in all key areas, namely: sexuality, safe motherhood, fertility regulation, avoidance of sexually transmitted diseases, pregnancy and childbirth, and children's health.

Council work on issues of male involvement has emphasized the importance of involving men as part of the social support women require as they pursue reproductive choice and health. It is not simply a question of whether men could or should use family planning more often—thereby providing women protection or alleviating their contraceptive burden (for example, reducing the disparity between the rates of female vs. male sterilization). Rather it is a question of to what extent men can and will offer their support for safe, voluntary, and pleasurable sexual relationships; discuss openly and take their fair share of fertility risks and inconveniences; provide support to their partners during pregnancy (by sharing the workload, for example); possess the knowledge about and be able to assist women during both normal and difficult deliveries (such as arranging for emergency transport); and participate meaningfully in children's wellbeing (such as ensuring that all children are immunized).

Within the International Programs Division we have encouraged applied research to learn more about how to appropriately foster social support for women's reproductive health, when and how to encourage greater communication between partners, and when and how to include male partners in reproductive health services. Programmatic work is currently being carried out in all of the Council's regional and many of its country offices in Africa, Asia, and Latin America as well as inter-regionally.

In the spirit of sharing what is being learned across regional boundaries, the South and East Asia regional office is pleased to present this summary of activities by researchers and nongovernmental organizations (NGOs) that have taken place in India. We hope that these experiences will encourage the fielding of more interventions to test appropriate means for including men across the full spectrum of reproductive health activities.

Workshop on Men as Supportive Partners

Our current understanding of empowerment has expanded. We believe that power has to be defined not in terms of “power over others,” but in terms of self reliance and inner strength, the ability to determine choices and exercise control over one’s own life. This holds true for women as well as men. Just as women need to liberate themselves from patriarchal strongholds, men need to be liberated, too, from the patriarchal construct of masculinity.

Social Action for Rural and Tribal Inhabitants of India (SARTHI) 1998

In the summer of 1998, the Population Council’s South and East Asia regional office convened a workshop entitled, “Men as Supportive Partners in Reproductive and Sexual Health,” in Kathmandu, Nepal that brought together more than 80 participants from a variety of backgrounds (research, media, donor organizations, NGOs, policymakers, activists, and filmmakers) to discuss issues relating to male participation in reproductive health care in South Asia, particularly India. To provide context for the meeting, Leela Visaria of the Institute of Economic Growth in New Delhi was asked to prepare an overview of the Indian situation vis-à-vis male partnership. Visaria reviewed close to 100 documents, including findings from both quantitative and qualitative studies, generated within India and abroad, to see what had been learned on such topics as: use of male contraceptives by Indian men; partner communication and its relation to decision-making in terms of fertility, contraception, and reproductive health; the sexual behavior and reproductive health needs of men; men’s perceptions of their role in sexuality and reproductive health vis-à-vis their partners; the perceptions of service providers and the health establishment regarding men as contraceptors or clients of reproductive health services.¹

Visaria concluded that there appeared to be gaps in knowledge and understanding in a number of areas. For one thing, it appeared that men were rarely asked about their own problems or views in this area. Further, she found that “research needs to go beyond estimations of incidence and prevalence and probe into power relations between partners” including the negotiation and decision-making process.

Anticipating the gaps identified in the literature review, papers were commissioned from prospective workshop participants who were asked to document their own work, through studies and/or interventions, involving men in reproductive health. The result was a background document, 534 pages in length, filled with actual field-level experience. This wealth of information on the practical aspects of implementing men’s involvement has not, in our experience, appeared elsewhere to date. Thus we have decided to bring out this volume summarizing these experiences so that they can be shared more easily with others in an accessible format.

¹ Copies of Visaria’s report are available from the Population Council, New Delhi.

Nongovernmental Organizations Pave the Way

Most of the actual field interventions described in this report have been undertaken by nongovernmental organizations. Unlike government programs that, for the most part, are still getting comfortable with the International Conference on Population and Development² rhetoric, NGOs have forged ahead through their community-based programs to include a focus on men. Although it is possible that the influence of the ICPD may, to some degree, have propelled NGOs' interest in working with men, the experiences reported here clearly show that in the overwhelming majority of cases, the decision to "include men" was neither ideological nor necessarily intentional; in fact, none of the NGOs focused initially or exclusively on men. Instead, *men were added as part of an evolutionary process, a consequence of ground realities showing that there could be only limited improvement in women's reproductive health without men's support and active involvement.* Given the dynamics of household decision-making on almost every aspect of reproductive health, *women themselves demanded that men be approached within the context of the various programs being undertaken by the NGOs.*

² Brief blurb on Cairo

The Case Studies

The case studies cover a wide range of activities from studies of attitudes and practice to descriptions of field activities and the conclusions that have been drawn from these experiences. In a few cases, grassroots NGOs have actually been able to incorporate small studies within their programs, the results of which have been extremely valuable to them in determining the course of their interventions; they also offer some numerical evidence of impact. Other NGOs describe their own experiences and perceptions of what has been successful and what has not.

All of the work documented here was done in India and is, therefore, reflective of the Indian context. At the same time the variations in attitudes and behavior across social, cultural, and geographical lines within India are sometimes stunning and often complex. Thus there are commonalties and there are exceptions, but we can learn from both because, more often than not, involving men means addressing underlying gender equations. We see these findings as potentially of interest to anyone addressing issues of male involvement whether they are in India, Southeast Asia, Africa, Latin America, Eastern Europe, or in developed country settings.

Status of Women, Family Planning, and Fertility

Organization

Research Centre for Women's Studies
SNDT Women's University

Type of Activity(ies): Study

This study, carried out from February – September 1995, analyzed the status of women vis-à-vis men in the city of Pune, Maharashtra State, focusing on educated women aged 15-44 years.

Participating Population

A final sample of women was drawn from 1,300 households; 1,063 eligible women were enumerated and from these, 980 women were interviewed. Data were also collected from spouses on issues of gender equality with regard to reproductive health and behavior.

Principal Findings

Women's status (conceptualized as women's relative position vis-à-vis men in decision making in economic and family affairs) significantly affects their ability to seek and implement maternal and child health (MCH) care and family planning services. In this study, decisions related to fertility regulation and maternal health care were reported to be taken jointly among most of the couples, with only a very small proportion reporting that such decisions are taken solely by the husband. Couples who took mutual interest and participated jointly in family matters reported greater sexual openness between partners resulting in enhanced marital satisfaction.

The study also examined preferences for contraception with 96 percent approving the use of permanent methods to limit family size; but only 71 percent approving the use of reversible methods for spacing or limiting births. Among current users of family planning methods, the majority (72 percent) had resorted to permanent methods; about 30 percent of the women approved the use of induced abortion to avoid unwanted births as well as when spacing between two children was insufficient. Almost 89 percent absolutely disapproved of the use of sex discrimination testing, indicating an implied disapproval also of sex-selective abortion. Fifty percent did not want any more children despite having only one living child. Among this group a significantly higher percent of the women who had one living son (57 percent) expressed such a view compared to those having only one living daughter (41 percent).

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Young Husbands' Involvement in Reproductive Health in Rural Maharashtra

Organization

Foundation for Research in Health Systems (FRHS)

Type of Activity(ies): Study

This 1995 study sought to determine married adolescent women's reproductive health needs and to assess men's current involvement in women's reproductive health.

Participating Population

207 in-depth interviews were conducted with married adolescent girls (74), husbands (37), mothers-in-law (54), medical officers (7), auxiliary nurse midwives (ANMs) from government health centers (25), and private doctors (10). In addition, a corroborating quantitative survey collected data from 302 married adolescent girls. Seventy-five percent of men reported their age at marriage as above 21, which is the legal age for males, whereas only one-third of the wives had attained the legal age for females of 18 years.

Principal Findings

The impact of marriage itself on the wellbeing of the interviewees was seen differently by men and women, with almost all the men describing marriage as having a positive effect on their personal life and assuming that their wives shared this opinion. Interviews with their wives, however, revealed that they had a different conception of married life: "Life is very different from what it was before marriage.... Initially I found it very difficult to cope with all this work. I used to hate it to the extent that I regretted getting married."

Responses to questions regarding the effects of illness on home life were uniform amongst men and women: both reported that illnesses of men created greater tension than sickness of women. Men's illnesses were seen as an immediate loss of wages, therefore a man falling ill resulted in immediate treatment and rest from work. When a wife became ill, her husband usually did not even know about it unless she herself informed him or the household routine got disrupted. Women reported that their decision to go for treatment or postpone it depended on the availability of money. Interestingly, educated women did not receive any more compassion when ill than their less educated sisters. As one husband reported: "I am sure she will go to doctor if she needs to. She is educated, she knows what is best for her health."

A lack of understanding about women's health problems and ignorance about family planning was summarily emphasized by findings from interviews conducted with husbands. *Although almost all men said that they did not want to have a child very early in marriage, two-thirds of them already had at least one child.* Except for one or two men who observed abstinence for the first 4-5 months after marriage, none of the others did anything to prevent conception. As one man reported: "I do not have much knowledge of family planning methods. The health workers never told me anything at all...." (Some men, in fact, actually viewed abortion as a spacing method and were not aware of the possible adverse effects of abortion on a woman's health.) On the other hand, wives felt strong social pressure to conceive within one year of marriage.

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Plans to delay the birth of a second child were more diligently mapped out, with many parents using some spacing method following the birth of the first child. Decisions regarding what method to use were always made by the men; the wife's views were not taken into account. As one man reported: "I would like to have one more child. After that my wife will get operated.

I have decided about this... I will convince her about it. Usually I try to convince her about my opinion. If she doesn't agree then I get angry."

Although a majority of husbands did accompany their wives for their first check-up to confirm pregnancy, the wife generally went alone or with some other female member of the family for subsequent visits. *Involvement of husbands in antenatal care was not expected and to some extent was seen as unnecessary interference.* In the few cases where the husbands did accompany their wives to a clinic, they were not allowed to enter the premises: Health workers told the men that other women clients would find their presence embarrassing.

Husbands also ignored women's health care during pregnancy, except for awareness of the need for antenatal registration and a nutritious diet. Men did advise their wives to reduce their workload during pregnancy; however, they themselves did not do anything to lighten the wife's burden, except in the case of nuclear families where husbands reported taking on more household chores.

Delivery and the post-delivery period were found to be exclusively a woman's affair. The men reported that even talking or inquiring about their wife and baby was not deemed necessary and most husbands were unaware as to whether or not their wives had experienced any problems during childbirth. These men did not see any need to learn about such possibilities, and actually saw such inquiries as unwarranted intrusions into female territory!

Follow-up Planned

FRHS planned to explore the possibility of involving men in existing reproductive health services and the education of adolescent boys. One possibility would be the provision of reproductive health education for boys in conjunction with a government program that provides tetanus toxoid inoculations for boys at age 16. Another proposed intervention was to provide first-level management of infertility at the primary health care level, using simple diagnostic tests such as sperm count. However, this second possibility was categorically rejected by government health officers who strongly believed such services would either be used indiscriminately or be misused in the rural areas. The officials also believed the number of men requiring such services to be too small to invest in the training and equipment required. [Interestingly, the popular magazine, *India Today*, recently did a feature story on increasing levels of infertility among Indian men.—Ed.]

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Sexual Behavior: Older Husbands, Younger Wives

Organization

Community Health Department (CHAD) -
Epidemiology Research Centre, Christian Medical
College

Type of Activity(ies): Study/Intervention

From 1995-1997, this study was carried out in a rural community of Tamil Nadu in South India to understand the sexual behavior of adolescents. The focus was on factors that influence the sexual behavior of adolescent wives and their spouses.

Participating Population

Interviews were held with 100 men (aged 20-45), their spouses (aged 16-22), "key informants" (health workers, traditional birth attendants, housewives, students, and teachers), and older men and women. Detailed information was compiled regarding pre- and extramarital sexual behavior, reproductive tract infections (RTIs), and general health problems, family planning and condom use, and abortion (including information on qualification of persons performing abortions).

Principal Findings

Regarding contraception, the study revealed that 72 percent of decisions to use family planning were made by the man. Therefore CHAD began holding bimonthly meetings for newly married couples about six years ago. About 10-20 couples attend these meetings and are given a kit containing condoms and a calendar to be used in following the safe period method.

Follow-up Planned

Based on the program's success, *the government has begun to replicate the intervention, introducing it through the Tamil Nadu Integrated Nutrition Program in the Vellore area.*

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Understanding Men's Reproductive Health Behavior

Organization

Survival for Women and Children Foundation (SWACH)

Type of Activity(ies): Study

Two projects attempted to reveal women's and men's attitudes towards reproductive health and the factors that influence these attitudes: a) reproductive tract infections amongst women of rural Haryana: an operational research study, and b) ongoing community-based research on understanding of men's reproductive health and the feasibility of specific interventions. The community-based research seeks to reveal differences that may exist between major caste groups in the area, i.e., scheduled and non-scheduled. The research will attempt to capture variations in perceptions, attitude, and behavior of men related to reproductive health.³

Participating Population

The RTI study collected data from 200 women aged 15-45 years, 100 men, 75 traditional birth attendants (TBAs), and 55 village health volunteers. The second study on men's reproductive health involves 120 adolescent and adult men balanced in marital status, religion, and age. In the project area (a community development block with a population of 140,000) 20 men per village will be selected for in-depth study. Half of the men will be married and the rest unmarried; half will be Muslims.

Principal Findings

Interestingly, the knowledge, attitude, and practice (KAP) study of RTIs, found that as high as 74.5 percent of women reported that they *do* share such problems with their husbands, and that their families are actually supportive of women with RTIs. In fact, knowledge about vaginal discharge was more common among men than knowledge about their own discharge, although what they "knew" was not necessarily accurate. Only one-third of men knew nothing about RTIs that affect men. Sixty-six percent of men interviewed thought that vaginal discharge signified having an RTI. In addition, it was encouraging that men did seem to understand that sexual relations with sex workers can result in RTIs and other reproductive illnesses.

As part of the community study, social mapping was used to select a homogeneous group of men. Older men were found to feel comfortable in the presence of older men, married men amongst married, and members of the same caste together. The men were concerned about keeping intact the prestige of their own community (group) although they would talk freely about the behavior of men from other communities. For example, in a group interview men were asked, "Do men have extra marital relationships in your village?" No one answered until one man said, "Not in this village." When later approached for an in-depth interview, the same man admitted that he had, in fact, had sex with two

³ The term "scheduled castes" refers to historically "underprivileged," "deprived," "depressed" or once "untouchable" castes. These castes were first categorized as "scheduled" by the British. Now the President of India identifies them for each State or Union Territory, in consultation with the Governor of the relevant State or Union Territory, for certain constitutional benefits.

unmarried girls. Such covertness and refusal to provide information were obstacles initially encountered in the social mapping exercise. However, sustained probing for 20-25 minutes was usually enough to overcome these hurdles.

Exploring the issue of condom acquisition and use, SWACH found that the village *dai* (traditional midwife) was the person most commonly approached for condoms by both married and unmarried men. However, *condoms* were rarely used, particularly for extramarital intercourse, as they are *considered to be a birth spacing method and are not seen as an aid for preventing reproductive tract infections*.

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Men's Sexual Health Problems in a Mumbai Slum

Organization

International Institute for Population Sciences

Type of Activity(ies): Study

At the time of this report, this study was in progress in a slum community in northeast Mumbai having a population of 70,000, who are mostly Muslims.

Participating Population

Data was collected via one-on-one, three session-long interviews with 56 men.

Principal Findings

It has been found that anxieties relating to semen loss, illness of *garmi* (heat), and itching problems were primary concerns among respondents who placed less emphasis on infectious and contact problems.

TABLE 1
Severity Rating of Male Sexual Problems (N=49)

Sr. No	Sexual Problem	Mean	Std. Deviation
1	Bent penis	1.9	0.8
2	Early ejaculation	2.0	0.8
3	Weakness	2.1	0.6
4	Burning urination	2.3	0.7
5	Gonorrhoea	3.2	0.7
6	White discharge	2.2	0.8
7	Lack of erection	2.3	0.8
8	Pus discharge	2.8	0.7
9	Syphilis	3.4	0.7
10	Boils/sores	2.4	0.7
11	Masturbation	1.6	0.8
12	Wet dream	1.4	0.6
13	Itching	2.1	0.9
14	Swelling	2.3	0.6
15	Lack of desire	2.0	0.8
16	Boils	2.2	0.8
17	Thinning semen	2.4	0.8
18	AIDS	3.9	0.4
19	Hydrocil	2.0	0.6
20	Skin sores	2.4	0.6
21	Heat	2.3	1.0

The high and sacrosanct value attached to semen emanates from the fact that the Sanskrit term used to refer to semen is *Virya*, which is synonymous with vigor and strength; and in popular terminology, semen is often referred to as "money." Since semen is considered to be the source of both physical and spiritual strength, the quality and quantity of semen, as well as its absence (real or perceived impotence), was of far-reaching concern to most men.

Men of all age groups and social classes in India reportedly suffer from erectile deficiency, premature ejaculation, or both, and Indian men spend large amounts of money seeking treatment. One estimate is that one out of every 10 Indian men is impotent and that almost two-thirds of cases of impotence stem from psychological causes.

The high and sacrosanct value attached to semen emanates from the fact that the Sanskrit term used to refer to semen is *Virya*, which is synonymous with vigor and strength; and in popular terminology, semen is often referred to as “money.”

The authors argue that the major sexual health concerns of men encountered during their research make it reasonable to assume that men's perceived sexual inadequacy not only adversely influences the quality of family life, but also may result in domestic and sexual violence. It is also likely to discourage men from using contraception.

The fact that several of these problems are gender-based, makes it important to understand clearly the socialization processes and influences that give rise to and perpetuate sexual myths, particularly among boys and men. Thus, there is a need to address the socialization process that begins in the home and continues at school. On both of these fronts, sex education that specifically addresses sexual beliefs needs to be available to children while they are still young.

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Perceptions of Male Members about Reproductive Health Matters: Preliminary Evidence from a Tribal Area of Gujarat

Organization

Action Research in Community Health and Development (ARCH)

Type of Activity(ies): Study

The objective of this 1996 study, carried out by ARCH, a voluntary group working for health and development in a tribal region of Gujarat State, was to understand men's perceptions as well as their existing knowledge about reproductive health in the rural village of Mangrol and surrounding areas. ARCH's previous work in the Mangrol region had revealed men's understanding of reproductive health to be extremely poor. Dramatic family break-ups and even deaths had resulted from misconceptions about when pregnancy is most likely to occur in the monthly cycle. Even male health workers were found to possess far less information and understanding of reproductive health issues and problems than female workers. However, the male workers were keen to encourage the active involvement of men in issues related to reproductive health. It seemed, therefore, that many of their visible biases were rooted in an utter ignorance of the scientific "facts of life" rather than any ideological resistance towards gender roles, so ARCH decided to explore the matter further.

Because men were more likely to be available at home in the evening, most of the interviews were conducted at that time. Closed and open-ended questions were posed to each interviewee on issues ranging from pregnancy and sex determination, to relationships between strength and *virya* (semen) and strength and *dhat* (vaginal discharge), to contraceptive methods that can be used for spacing.

Participating Population

Over 15 days, 50 men aged 15-37 were interviewed. Half were married and half were unmarried.

Principal Findings

From this study, ARCH has drawn two main inferences: first, that lack of male involvement in reproductive health programs may not be as acute as supposed; and second, one of the most important reasons for the perceived "neglect" by men may be related to a serious lack of information regarding reproductive health matters.

ARCH's first inference is based on the generally high levels of "correct" answers given by the men interviewed (which may be attributed to a fairly large proportion of respondents being non-tribals and educated youth). When asked about a woman's care during pregnancy, most respondents talked about dietary prescriptions and proscriptions, and the need for her to reduce her workload and take rest. Few specifically mentioned antenatal care, [iron] tablets, or [tetanus] injections. Also, when asked to explain why their wife should undergo surgical sterilization instead of themselves, the respondents stated that this would avoid the problem of husbands being sterilized and their wives then becoming pregnant [something that occurred rather frequently in years of the vasectomy camps—Ed.]. ARCH speculates that although such responses may imply an acceptance of the possibility of post-vasectomy pregnancy, the tone of the answers seemed to indicate an assumption by men of infidelity among women, and a desire to keep it under wraps to avoid social turmoil.

Forty-three out of the 50 men interviewed identified condoms as a method of birth control. ARCH is, however, quick to emphasize that its data set does not deal with the question of *actual use* of condoms. In fact, experience in the field area suggests that condom use is rather uncommon. Despite this, there exists reasonably widespread awareness that vasectomies generally do not have negative side effects. Men also knew that childlessness within marriage is not necessarily the woman's fault and that AIDS is spread via sexual relations, blood transfusions, and unclean needles.

In spite of such awareness, misinformation and lack of information were evident. Although generally aware of how pregnancy is initiated, many interviewees were unclear about when during a woman's menstrual cycle she is most likely to conceive. Similarly, loss of *virya* was described almost unilaterally as relating in some way to a loss of strength. [It should be noted that in many Sanskrit-based Indian languages, the word *virya* can be used to denote both semen and strength—Ed.] Limited availability of information was underscored by the fact that only four of the 50 men interviewed had sought answers to reproductive health questions at health clinics, and only two had actually spoken to a health worker once they were inside the clinic.

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Beginning of a Process: Male Involvement in Reproductive Health

Organization

King Edward Memorial (K.E.M.) Hospital Research Centre

Type of Activity(ies): Study

This study, undertaken from June 1995 to December 1996, sought to document reproductive health knowledge and awareness levels among adolescents in the rural outskirts of the city of Pune.

Participating Population

The study was carried out to facilitate the design of an intervention package. The adolescents participating in the study were recruited from an area typified by moderately developed communities having access to facilities such as improved roads, communication, and economic opportunities. Nonetheless, behavior continues to follow traditions such as early marriage, strict caste segregation, and preferences such as cross-cousin marriage. Bigamy is also rampant among the older generation.

Principal Findings

Study findings indicate an expressed demand for information on sex-related issues. Boys and married adolescents of both sexes specifically wanted to know about the effects of masturbation, consequences of loss of semen, excessive indulgence in sex, menstruation, pregnancy and AIDS. Although many married women did explicitly ask researchers, "Why should boys know about menstruation or pregnancy? It doesn't happen to them," there was high demand for boys to receive sex education voiced by unmarried girls who said, "Boys must know about these things so that they will be more caring towards their own wives."

Participatory tools used in some interviews included mobility mapping and body mapping. Whereas boys completed such exercises very quickly, girls were hesitant, shy, and suspicious of what might be done with the results. Poor knowledge about sex-related issues was typified by an adolescent girl who, when asked what she meant when she said that AIDS was caused by *anaitik laingik sambandha* (immoral sexual relations), answered that she did not know what *anaitik laingik sambandha* meant.

Girls said they had received information on menstruation from their mothers, but that it was mostly restricted to behavioral proscriptions during menstruation and about sanitary protection. Overall findings from boys revealed a lot of concern about and preoccupation with semen. Forty-five percent of married and 31 percent of never-married males felt that semen gets exhausted at a later stage in life.

Male adolescents' median age at first sexual experience was 17 years. They admitted having sex with sex workers only a few days before marriage, either due to peer pressure or performance anxiety. Only 27 of the 150 married men and four of the 100 unmarried men reported having used condoms. One-third (33 percent) of the married male respondents reported that their first sexual experience was painful and they had felt nervous or scared. Nearly the same proportion of married men reported indulging in masturbation. As high as 82 percent of the married men, and 95 percent of the unmarried men, said they had heard about AIDS.

Pressure for newly married girls to get pregnant soon after marriage seemed to come overtly from the mother-in-law, but in reality she appears to be only the mouthpiece for the concerns of the entire kinship circle. Men were found to play almost no role in antenatal and postnatal care, which was considered exclusively a woman's domain.

The study also revealed the importance of training research personnel in how to talk comfortably about sexuality. On several occasions, male members of the research team lacked self-confidence when asking men questions about their sexual behavior.

Gender discrimination was found to begin as early as the intrauterine stage when older women in the family and neighborhood begin to guess the sex of the child. They do this using certain “ethno-diagnostic” methods [these may include the shape of the stomach, the kind of food the expectant mother craves, or even the way she is walking—Ed.].

Follow-up Planned

KEM was using the findings from the study to design an intervention program consisting of: a) education/information on reproductive biology, counseling, and clinical services for gynecological morbidities, and b) targeting school-going adolescents by training teachers and other resource persons in sex education. For out-of-school adolescents, there will be a series of planned gatherings variously called *Kanya Mandals*, *Yuvati Vikas Kendra Mahila Mandals* and *Bhajni Mandals* (all meant for girls and women) and *Tarun Mandals* (meant for boys and young men). A clinic will also be set up in the project area and services will be provided at a time and place most suited to adolescents living in the villages.

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Promoting Safe Sex Through Improved Gender Relations

Organization

Sexual Health Project (SHP), Family Planning Association of India (FPAI)

Type of Activity(ies): Study/Intervention

The FPAI is carrying out activities at two sites in India, Chennai and Lucknow, as part of a larger, international effort. Since misconceptions adversely impact reproductive health, group discussions as well as face-to-face interactions are being carried out on this topic. Initial discussions were held with women, but as the project evolved the important roles played by men became clearer, so men were also drawn in to help the community identify and prioritize their needs. In the process, about 100 women and 64 men were identified to act as “volunteers.” Interventions were developed at both the community and service-delivery level. While the first required that the community take their own initiative, the second required the involvement of medical personnel. This latter need was met through the referral services of FPAI.

Participating Population

In Chennai, the focus is on an urban population, whereas in Lucknow the concentration is rural. These pilot projects began in July 1994 and were due to conclude in December 1999. As of the date of this report, approximately 2,400 households have been covered, approximately half located in one of Chennai's slum areas. Although the project is not targeted at any specific age group, participants are essentially between 15 and 30 years of age.

Principal Findings

FPAI already had several activities in place in Chennai, so the SHP has been able to draw upon existing women link leaders and urban health post staff to act as health educators. These educators started talking with married women to get initial feedback on myths and misconceptions within the community and learned that in Chennai these include:

- Sex means intercourse.
- Sexual relations are a satisfying activity for men; for women, a reproductive activity.
- Sexually transmitted infections (STIs) occur if a man has intercourse with a menstruating woman.
- Women are solely responsible for determining the sex of the child.
- The sexual urge is reduced in persons who have undergone vasectomy.
- Only males indulge in homosexual activities.

Research also revealed that coercive behaviors such as incest and sexual abuse were prevalent among the population surveyed.

Some lessons learned from the project include:

- The importance of being sensitive to people's work schedules.
- When involving men in a health program, services should be offered in a separate room or at different hours from those offered to women.
- Men in the middle-income group, in particular, may not be receptive in the beginning, and some resistance to holding group discussions with both sexes together still exists.
- Whatever was discussed in the girls' group was shared with the boys' group and vice versa, paving the way to greater openness.
- Quoting from real-life incidents proved effective in facilitating better understanding among the participants.
- Women readily allowed their adolescent daughters to speak about sex and sexuality and encouraged them to take an active part in the project.

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Men's Involvement in Women's Health: The SARTHI Experience

Organization

Social Action for Rural and Tribal Inhabitants of India (SARTHI)

Type of Activity(ies): Intervention

Through the experience and evaluation of multiple programs, SARTHI has accumulated valuable lessons in gender and health issues. Specifically, two programs have provided valuable learning experiences: including men in women's health programs and effective STI education.

In 1991, SARTHI evaluated its maternal and child health program to measure the effectiveness of their training of women health workers as compared to a control group in a non-project area. One aspect of the survey looked at the differences in the perception and awareness of men in the project and non-project areas with respect to the quality of health care provided to women.

SARTHI also carried out two small studies on (a) men's perceptions of illnesses of the "nether" (genital) area and (b) attitudes and perceptions of men and youth about sexuality and related matters.

Participating Population

SARTHI works in approximately 150 villages in predominantly rural areas of Panchmahals District in Gujarat.

Principal Findings

Results of the evaluation showed more men reporting that their wives had problems with their last deliveries in the project area as compared to the responses of men in the control (non-project) area. This was seen as an indication of either better rapport between men and birth attendants in the project villages or just greater awareness among men due to the health education efforts taking place in the community.

Almost 77 percent of those whose wives were pregnant at the time of the study reported that the birth attendant had told them that their wives required special care during pregnancy, as contrasted to 39 percent in the non-project area. Men in the project area also proved to be more knowledgeable about the introduction of weaning foods and if their wives had received tetanus toxoid and iron folic acid supplements. Finally, almost 84 percent of men in the project area (as compared to 41 percent in the control area) believed that their village birth attendant had been able to bring about a decrease in local women's suffering. These findings validated SARTHI's impression that their training efforts were having a positive effect in the villages and that men appreciated this fact.

Although men had not been consciously considered as a target group for health education or sensitization to gender issues, the data revealed that SARTHI's work on women's health was having an indirect impact on men's levels of knowledge and sensitivity to gender issues in the project villages. Surprisingly men did not consider women's meetings to be threatening to their power base and they indicated a willingness to take on some domestic chores so that their wives

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could participate in SARTHI activities. Obviously the men saw some obvious benefits for them and their families due to women's participation. From this point forward, SARTHI began to formulate a strategy that would include men in the women's empowerment and health program and began training men as health workers as part of a new General Community Health Program providing health services to men and children.

Another significant event in SARTHI's experience was trying to address the frequency of STIs. To be effective SARTHI knew that training programs had to reach men as well as women. In April and August 1994, SARTHI organized two clinical camps for the diagnosis and treatment of STIs and reproductive tract infections (RTIs) among men and women in the area. Low attendance rates indicated that *for women, access to health is not just a matter of physical access but includes an important component of social access*. Many women backed out when they did not obtain their husbands' permission to attend.

Along with clinical camps, SARTHI also carried out two small studies on (a) men's perceptions of illnesses of the "nether" (genital) area and (b) attitudes and perceptions of men and youth about sexuality and related matters. Unfortunately, the principal investigators, due to age, gender, and social class issues, were uncomfortable with communication about sexual health issues. All these difficulties convinced SARTHI that *staff members needed to overcome their own internal barriers and increase their openness and sensitivity to sexual matters if their efforts were to succeed*.

SARTHI's research also convinced them that the health camp approach had severe limitations and was not addressing important problems like third-degree uterine prolapse and widespread infertility. At the same time, SARTHI staff felt that further data gathering and research would be unethical given people's immediate problems. Therefore, in April 1995 SARTHI moved from having two separate components—women's health and community health—to addressing gender issues within the general community health program. The staff structure also changed to a team of one male and one female health volunteer working together with the woman client as well as her partner and other significant men in the household. Thus far the reorganization effort has proved to be a mixed success.

Here too problems arose with the gender relations aspects of the training, so a fertility awareness educator was brought in to conduct a series of four workshops for all SARTHI staff, both male and female. The training program, *Shareer se dosti* (making friends with the body), was initiated using the technique of body mapping. Participants were asked to mark on a body outline which body parts gave them *dukh* (or pain) in red, and the parts where they felt *anand* (or pleasure) in green. Only a few men could relate "pleasure" with foreplay and/or actual sexual contact with women, especially in front of a mixed audience of women and men.

In order to overcome this reticence, *Savaali Ram ni Peti* or "Mr. Question Box" was introduced. This technique allowed participants to ask questions anonymously and, therefore, more candidly and proved so successful that the health workers decided to introduce *Savaali Ram ni Peti* in the villages. They also decided that they could read the weekly question-and-answer sexology column in a leading Gujarati newspaper as a way of more candidly presenting information.

Some other conclusions drawn by SARTHI include the need to work with men of all ages as older men hold most of the power, including giving permission to go to the hospital. Men in the reproductive age group need and want to be sensitized to women's needs during pregnancy, childbirth, and lactation, but do not have basic knowledge about sexuality and reproduction.

It took SARTHI several years to recognize the fact that *women's empowerment and men's sensitization need to be done simultaneously, as parallel processes*. Just as women need to liberate themselves from patriarchal strangleholds, men also need to be liberated from patriarchal constructs of masculinity. Personal transformation, empowerment, and an understanding of gender relations are necessary before male health workers can become good role models in the community. To this end, *training on sexual health needs to be experiential and participant-centered rather than clinical and trainer- or topic-centered*.

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Involving Men in Women's Health Programs

Organization

Child in Need Institute (CINI)

Type of Activity(ies): Intervention

CINI's ongoing efforts to improve the health of women were challenged by local women and members of the *Mahila Samity* (village women's groups). Their main contention was that most of their male partners suffered from white discharge, and that the men required treatment for these problems. CINI then assessed men's present awareness, their roles, and their sensitivity to their partner's reproductive health status through a series of focus group discussions and, based on the results, began a field intervention.

Another CINI program is working with adolescent girls. Girls entering puberty were found to be ignorant of menstruation and reproductive health issues. In addition, numerous cases of sexual abuse and forced unprotected sexual episodes were revealed in discussions with the girls, as was their pervasive ignorance about their own bodies. Beyond the value of coming together to discuss these issues, the girls were given reproductive health kits and other information, education, and communication (IEC) materials for their own use. (The need for a similar kit for adolescent boys also became apparent.)

Participating Population

Pilot projects in four villages (Abjakhali, Dakshin Bagi, Khariberia, and Bhasa) in the 24 Paraganas (south) District of West Bengal have introduced a reproductive health component serving a total population of 120,000.

Principal Findings

Focus group discussions (FGDs) revealed that men are generally ignorant about their wives' reproductive health; the men regularly expressed the opinion that pregnancy prevention is a woman's, and not a man's, responsibility. In response, CINI's Reproductive and Child Health (RCH) project team initiated an awareness campaign in four project villages, spearheaded by 20 trained peer educators who

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organize meetings and disseminate information. The success of the intervention has been evident in the increasing number of men and women accessing services provided by CINI programs. Moreover, the peer educators themselves have begun to think about and question nonegalitarian gender relationships within the family. Peer educators have also reported that newly married young men *are* willing to listen to discussions of new and gender-sensitive ways of approaching women's health. These men do, however, continue to be paralysed by immense social pressures from elders, particularly older women of the family. This has led CINI to emphasize that *to be effective, any intervention program for women's health needs to involve all family members, not just the husband and wife.*

CINI reports that men from the surrounding area are now agreeing that their wives go for treatment and are, themselves, attending the male clinic. In the Hindu villages, the men have become quite well sensitized and are aware of their roles and responsibilities in sexual and reproductive health. In the Muslim villages, efforts are now on overcoming whatever religious barriers remain in terms of access to and utilization of reproductive health care.

Initially, CINI's program for adolescent girls was met with considerable resistance from the community, which felt that there was no need for girls to know more about their bodies. And although CINI works in predominantly Muslim villages, they found that Muslim families were not particularly averse to their girls receiving information about their bodies despite the additional constraints imposed by their religion. In fact, CINI workers have found Muslim women to be more enthusiastic than their Hindu counterparts in accepting birth control methods, and much more forthcoming in revealing or discussing their husband's exposure histories.

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Working With Men to Improve Reproductive Health in a Delhi Slum

Organization

Community Aid and Sponsorship Program and Foster Parents Plan International (CASP-PLAN)

Type of Activity(ies): Intervention

Spurred on by women asking the question, “you are making us understand everything but who will make our husbands understand?” CASP-PLAN developed an initiative to involve men in a reproductive health program in Sangam Vihar, an unauthorized urban slum in Delhi.

Participating Population

Sangam Vihar has a population of approximately 100,000 residing in 20,000 dwelling units spread over 150 acres. The area lacks access to basic civil amenities and has no government dispensary/health center, nor is there a referral hospital within a radius of 5 kilometers.

Principal Findings

Advertised with posters, loudspeaker announcements, and door-to-door solicitation by Community Health Guides, CASP-PLAN’s workshops for men provide information on antenatal care (ANC), reproductive health, STI/HIV/AIDS, sex determining factors, and facets of the man’s role in the family. *Experience has shown that interest in participating in the workshops is initially generated by taking a child welfare rather than reproductive health approach.* The wellbeing of children is a subject that resonates well with most men.

Approximately 25 such workshops have been conducted at the time of this report, providing information to approximately 4,000 participants. *Increases in ANC attendance by women in their first trimester of pregnancy have been attributed to men’s participation in these workshops.* Hurdles encountered in designing the male workshops have related primarily to issues of timing and scheduling. Weather conditions in Delhi are such that November to March were found to be the only months in which the workshops could be held and attract a sufficient number of participants. Also, successful attendance was attained only when workshops took place on Sunday, when most men do not have to work. However, identification of staff willing to participate in workshops on Sundays became problematic. Workshop timing also had to take into account popular events: men were keen to watch a popular TV serial, *Mahabharat*, airing Sunday mornings up until noon. Finally, identification of appropriate physical space to hold the workshops has also been problematic.

The most formidable obstacles the project has faced are not related to logistics, but in achieving attitudinal change. Despite positive responses from men, however, translating these into follow-up action has been very difficult. Men were found to have difficulty internalizing the messages and putting them to use. Also problematic is the persistent view that pregnancy and childbirth are matters to be handled strictly by women, as well as the continued practice by ANC clinic staff of asking men who do accompany their wives for check-ups to wait outside, making their effort feel useless.

The healthy couples’ program consists of training workshops for 50 couples. Whereas many men initially responded very enthusiastically to the idea of such a program and agreed to work as volunteers, in reality very few ultimately attended, making the project only partially successful.

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Sangam Vihar's male clinic is staffed by a full-time male doctor who is available at hours convenient for male clients. The clinic is advertised as a "male clinic" instead of an "STI clinic," despite the fact that most of its work centers around treatment of STIs. Many clients attend the clinic at the urging of their wives, who themselves have been diagnosed with STIs.

Significant lessons learned from CASP-PLAN's work with men include:

- The importance of reinforcement through repetition.
- Selecting the appropriate way to present information—for example, men are more responsive when events are identified as being focused on the wellbeing of children rather than on reproductive health.
- The need for IEC materials and messages to be precise and specific.
- Three to four years is an inadequate amount of time to bring about change in attitudes.

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Enhancing Roles and Responsibilities of Men in Women's Health

Organization

Society for Education, Welfare and Action (SEWA)-Rural

Type of Activity(ies): Intervention

SEWA-Rural's experiences in attempting to include men in women's health are categorized in terms of a safe motherhood initiative, a program for newly married couples, and distinct family planning and adolescent health awareness programs. SEWA-Rural sought new ways to revise their approach to maternal health care through involving men and other family members in preparing for safe childbirth by supporting women in registering early, obtaining adequate nutrition, planning ahead for delivery, recognizing signs of complications, and ascertaining appropriate action should complications arise.

The strategy used to remind pregnant women and their families of the anticipated delivery date is to inscribe this date on the walls inside the family home, using appropriate references to events on local calendars. SEWA-Rural also uses a postcard system to inform families of the expected delivery date, remind families of the impending doctor's appointments, and reinforce the need for special care in abnormal circumstances. At the time of this report, some 342 postcards were being sent out every year. The safe motherhood initiative also involves field visits tailored to accommodate men's schedules.

SEWA-Rural's health workers (men and women) have also started a program to initiate rapport between newlywed couples. It consists of meetings that attempt to organize discussions with the couple alone, as well as with the couple joined by their elders. The program also includes a *Nav Dampati Mela*, a fair organized each season that includes games and discussions designed to stimulate health awareness. In addition to various IEC materials, SEWA-Rural also provides gift packs containing trinkets and an appropriate gender-specific sample contraceptive (condom for men, regimen of oral pills for women) to newlyweds. An interesting twist is that the box of pills is given to men and the condoms are given to women in an attempt to initiate discussion between the husband and wife.

Participating Population

Men, women of childbearing age, and couples in the project area.

Principal Findings

The initiative's overall success is evidenced by a *40 percent increase in the number of men seeking out health workers to register their wives for early antenatal care* and the fact that, on average, one out of three women is now accompanied by her husband on visits to the hospital. There has also been a significant increase in the number of fathers who have started bringing their young infants to hospitals for immunization.

What is less encouraging are the observations that men, family members, and women themselves persistently believe that a man must not be present during his wife's labor. Moreover, all family members, including women, are reluctant to have men donate blood for their wives—even in critical situations—for fear that this will physically weaken the husband.

Currently the Indian government provides a stipend for those living below the poverty line for each of their first two deliveries. SEWA-Rural has noted that this incentive does stimulate a few husbands to

complete the formalities necessary to get this money. However, since the money is dispensed *before* the woman gives birth, at the insistence of the husband and other family members it is usually used for expenditures unrelated to the health or welfare of the pregnant woman or expected child. For this reason, health workers have started explaining the importance of nutrition for pregnant women and new mothers to men and other family members.

With the newlyweds program, senior family members initially were apprehensive about newlyweds taking part in any discussion of reproductive health matters. However, reinforcing the need through repeated contacts has resulted in almost three out of four families becoming receptive to the idea. Also encouraging was the realization by couples that delaying the birth of their first child is important for both maternal and child health. Most couples are eager and interested to learn more about reproductive health matters; it was actually the health workers who had more trouble shedding their own inhibitions and preconceived attitudes about sexual behavior than the newlyweds.

In the process of carrying out their programs, SEWA-Rural has also realized that health and wellbeing need to be approached in a holistic manner, where the family is seen as a unit and a comprehensive package of health services is delivered. In addition, the underlying fabric of socio-cultural traditions and the economic milieu have to be kept in mind when introducing any strategy aimed at addressing men.

Early rapport between health workers and newlyweds was seen as crucial to program success. Once established in the community, health workers who have demonstrated their capacity to effectively manage ailments can help to ensure the active participation of both men and women in programs and services. In their adolescent health and awareness initiative, SEWA-Rural has found that multiple, ongoing sessions with the same group, over a period of time and covering a few topics per session, are most effective. They also stress the important role played by their team of male *and* female health workers who can serve as role models in motivating couples to establish healthier reproductive habits. In particular, male health workers can assist in motivating men in the community and they have proved to be a vital link in the effective functioning of adolescent groups.

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Narrowing the Gender Gap by Enhancing Men's Involvement in Reproductive Health

Organization

Centre for Health Education, Training and Nutrition Awareness (CHETNA)

Type of Activity(ies): Intervention

CHETNA has been involved in three intervention projects. One initiative emphasized the role of men in early childhood care and development, another involved adolescent boys in health and development programs, while a third focused on the use of training as a platform to involve men in women's health.

Motivated by responses from women emphasizing their lack of power even over their own food intake ("Why don't you give this advice about what I should eat to my family members. If I start eating what you suggest, my husband and mother-in-law will beat me."), as well as indications of neglect by husbands and the effect it can have for their wives' health ("It is cheaper to remarry than to spend money on treatment. I don't mind waiting for the death of my wife."), CHETNA began to involve men in their reproductive health programs in the early 1990s.

Parents' camps, consisting of instructions on childcare and related issues, which traditionally have been attended only by women, were rescheduled and redesigned to welcome fathers' participation. Specifically, it was necessary to hold the camps in the evenings in order to accommodate men's work schedules. The specific camp programs, however, were not otherwise modified. It was found that gradually, over time, men began to appear at these camps, displaying noted interest in sessions that focus on growth monitoring and the relationship between proper food intake and their child's physical growth. CHETNA also redesigned their IEC materials in a way that encourages male involvement in infant care, challenging the stereotypic image of women as sole caregivers by including men in the illustrations; for instance the cover of a weaning food manual now portrays a man feeding his infant child.

Adolescent camps have also extended their activities to include boys. Although considerable objection from parents, the camps have been successful in generating basic physical awareness on the part of adolescents. One exercise used involves body mapping, where basic organ identification and function is taught. Body mapping exercises are also planned for men, wherein the internal and external reproductive organs of both women and men are to be clearly depicted and explained.

Participating Population

Local men and male adolescents; male health workers.

Principal Findings

CHETNA's experience emphasizes the importance of involving men in reproductive health, including training and gender sensitization of men, particularly male health workers. Based on lessons learned during their various training programs, CHETNA has concluded *that it is better to have no male trainer than to have one who is insensitive to gender issues*. However, trained and gender sensitized male health workers have been able to motivate men in the community to contribute towards

women's health, and have played an important role in sensitizing their male co-workers within the organization.

One important problem identified was that *when community men become open to gender equality, they often report facing criticism and humiliation within the extended family when attempting to assist with housework or take on some of their wives' responsibilities*. Not only are their attempts to help criticized by elder members of the family, both male and female, as well as within the community, but in some instances their help is not even appreciated by their wives! Thus CHETNA plans to carry out a training program for both the women's spouses and family members because *it has become obvious that family members and the community need to be an integral component of male involvement efforts*.

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Encouraging the Involvement of Males in the Family

Organization

Family Welfare Education and Services (FWES)

Type of Activity(ies): Intervention

The Family Welfare Education and Services (FWES) project, started in 1992, advocates active involvement of men in the promotion of contraceptive use in the community, while a second project seeks to impart reproductive health education to adolescents.

As part of this project, continuous contact is maintained with villagers through village family welfare workers (VFWWs) and village organizers (VOs). VFWWs have been trained to diagnose common health problems and treat them at the village level. More serious problems are handled by VOs during routine weekly visits.

The experience gained from implementation of these projects has resulted in many innovative ideas. For example, realization that the authority for taking any decision rests with men, and that the mother-in-law is an important catalyst, has led to the creation of men's and mother-in-law clubs. The premise of the former was to identify a few select men exhibiting positive attitudes towards the program who are more receptive to change as "champions among men." They, in turn, would help spread the message to other men about their role in the wellbeing of their families. Held once every two months and chaired by one of the village leaders, club meetings consist of discussions about social issues such as alcoholism, smoking, malnutrition, family planning, and women's literacy.

Sasu Sammelans (mother-in-law clubs) meet approximately once a month. The aim of the clubs is to garner social acceptance and approval for the concept of positive reproductive health outcomes in the community. Giving colostrum to the newborn is, by far, the most frequently discussed topic. Mothers-in-law are also motivated to encourage their sons to take proper care of their daughters-in-law because "only a healthy and happy mother produces a healthy child."

Participating Population

The projects focus on 30 selected villages in Kheda district, Gujarat State.

Principal Findings

Thus far the men's clubs have met with limited success. Attendance has been poor and the composition of the groups tends to remain virtually unchanged from meeting to meeting.

The FWES project is based on a philosophy of integration, whereby family planning activities have been merged with wider concerns for nutrition, maternal and child health and subsidized medical care. Another positive feature is the fact that project staff belong to the same village where they work. Overall success of the male involvement project is revealed by increases in girls' enrolment in schools as compared to decreases in neighboring villages. FWES project villages also have not experienced any change in sex ratios whereas neighboring villages have experienced a steep decline in female births.

FWES appears, however, to have reached a plateau in its achievements after initial successes, and it has become more difficult to progress beyond this point.

The reproductive health education for adolescents project consisted initially of community based surveys to assess awareness/knowledge among both adolescent girls and boys in rural as well as urban areas, including those attending schools and colleges. The findings from the surveys were used to help convince community leaders of the importance of incorporating some form of reproductive health education in the school curricula.

Initially it was decided that teachers would be the ideal people to impart such knowledge. Actually there were hardly any other options as parents simply refused to talk about such matters with their own children. However, despite the survey findings, only a few teachers volunteered. Subsequent discussions with teachers revealed that they themselves held many misconceptions and confusions about sexuality and what constitutes normal human sexual behavior. These teachers thus expressed hesitance to discuss such matters with their students in a classroom setting.

As a result, the “letterbox” approach was developed, wherein questions about sexuality/reproductive health are placed anonymously in letterboxes (one for girls and one for boys) and then answered by a team of trained teachers in formal answering sessions. In the case of co-educational institutions, and separate sessions are held for boys and girls. Letterboxes have already been installed in approximately 40 percent of educational institutions in the project area of Anand Taluka and regular sessions are now being conducted in more than 55 institutions. It has been suggested that these efforts should evolve into the formation of adolescent boys and girls clubs in the villages.

The questions most frequently asked by students from 12- to-14 years old pertain to the mysteries of adolescent development, both physical and social, acceptable sexual behavior and questions about the opposite sex. Girls of this age are predominantly preoccupied with the process of menstruation, asking many questions on pregnancy and inquiring why only women get pregnant. Girls 14-18 continue to ask questions about menstruation but appear to be more concerned about their overall appearance. Questions about whether girls also ejaculate are frequent. Older girls, age 19 and above, ask questions about the sexual behavior of adults. Doubts and problems related to first sexual intercourse are also expressed, as well as about climax/orgasm, masturbation, and virginity.

Among boys, frequently asked questions concern nocturnal emissions, homosexuality, and the normal sexual response in boys and girls. Many adolescents harbor myths about the normal anatomy and physiological processes of the body. Slightly older boys are concerned with “self,” masturbation, the sexuality and sexual feelings of girls, and condoms. Boys aged 19 and above are concerned with size of penis, methods and diets to prolong the sexual act, premature ejaculation, and virginity among girls, while questions on masturbation continue. Boys at this age seem to be more likely to ask questions on male menopause as compared to any other age.

Over the years, with the establishment of two local health centers offering services for adolescents, there has been a definite change in the types of questions being asked. *There has been a significant decline in questions from boys with respect to such discriminatory topics as virginity of the girl, and an increase in questions addressing issues such as involvement of males in family matters, and the male’s role in raising children.* Questions about STIs, AIDS, contraception, and safe sex practices are also frequently asked. It is important to note that boys are now more likely to ask questions related to the process of menstruation in girls, expressing increasing concern towards perceived problems faced by girls. Significantly, a larger percentage of boys now view sex as not merely a process for deriving pleasure or a means for procreation, but regard it as a part of the phenomenon of “expressing and sharing love.”

As they mature, girls continue to express a preoccupation with their physical appearance but start asking questions about masturbation, safe sex and contraception. Significantly, more girls now regard sex as a process of sharing love, as opposed to the earlier notion of making babies. Similarly, more girls now express a demand for equal sharing of daily household chores and in the upbringing of children with their future partners as compared to their peers four or five years earlier.

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***Purush*: Male-Only Clinic**

Organization

Parivar Seva Sanstha (PSS)

Type of Activity(ies): Study/Intervention

At the time of this documentation *Purush* had only been open for a few months so no lessons or experiences from the clinic's actual operation could be documented. However the experience of setting up the clinic was shared. Since it was a pioneering effort, extensive research and baseline activities were carried out by PSS prior to its establishment.

Purush's specific approach to service delivery is based on an understanding that men's sexual behavior is rooted in the psychosocial milieu and thus far there have been few, if any services, that focus on the whole man and not just on contraception or treatment of STIs.

Participating Population

Purush Male Clinic opened in 1998 in Chennai, capital of Tamil Nadu state. It caters specifically to sexually active males aged 18-45 years with a monthly family income of Rs. 500 to Rs. 4,000 (approximately U.S.\$12 to \$100). However, in practice, *Purush* is open to any man in need of services, including adolescents.

Principal Findings

Background research dictated that the clinic should offer integrated services in order to avoid clients' being excluded or stigmatized because of their use of the services. Locating the clinic in a populated, high-traffic area, was found necessary in order to replace the image of reproductive health clinics as being "dingy, back-alley operations." Proximity to the women's clinic was also deemed necessary to facilitate care for the entire family.

Interestingly, the naming of the clinic generated much discussion as names like Adam and Mister were found to conjure class-linked images that might deter some men from accessing the services. They were discarded in favor of *Purush*, which did not seem to have any negative connotations and could be easily pronounced and translated in the local Tamil language.

Follow-up Planned

Since this report was prepared, Parivar Seva Sanstha has established another men's clinic in Cuttack, Orissa State.

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Reaching out to boys

Organization

Council for Sex Education and Parenthood (International)

Type of Activity(ies): Intervention

Mahinder Watsa has worked in the reproductive health field in India since the 1970s. His work has constantly revealed a common unmet need for better interpersonal relationships, gender sensitivity, and addressing different aspects of human sexuality in India. His specific focus is on adolescents and their need for accurate and empathetic information on sexual matters.

In 1988, Watsa conceived “Spearhead Youth Health,” a replicable and sustainable program, specifically targeting urban adolescents. Activities are being conducted nationally, at least twice a year, and focus on the development of peer group leaders. Approximately 70 to 100 youth are selected to participate in this three-day training program.

Participating Population

Indian males, aged 15-30 years.

Principal Findings

Indian males are seeking answers to questions centered around the male genital organs, masturbation, night emission, concerns about sexual performance, and partner relationships. Women report that they want their men to: take responsibility to end alcoholism, gender-based violence, rape, and sexual abuse of women and girl children; make sexual relations a shared pleasure; accept the man’s role in infertility and acknowledge that the sex of the child depends the contribution of the male sexual partner. In workshops and meetings that have been documented, (one of which was titled “The Caring Male”) it became evident that both parents and teachers were ignorant as to how to convey sexuality education to young people.

To date the following lessons have been learned:

- Young people can take leadership and behave responsibly to propagate reproductive health goals.
- Family planning and reproductive health topics can be approached successfully.
- Counseling facilities are necessary and should be introduced at the point of need.
- Youth programs are helpful in changing sexual behavior.
- Sexual health programs must be realistic and need-based; values, interpersonal relationships, and decision-making should be stressed.
- Care, patience, and persistence are needed to overcome barriers.

In sum, the author maintains that a health program for young people by young people is both replicable and sustainable. A program of this nature requires a low budget since it relies significantly on personal motivation and the integrity of voluntary workers who are available whenever the community needs them the most.

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Halting AIDS on the Highway

Organization

Bhoruka Public Welfare Trust

Type of Activity(ies): Intervention

In 1993, Bhoruka Public Welfare Trust surveyed truck drivers passing through strategic stopping points on highways in terms of their sexual behavior. As a result, intervention centers were set up, offering drop-in-centers-cum-clinics with referrals to medical officers, and outreach. Previous research undertaken by the Bhoruka Public Welfare Trust (operating under the umbrella of TCI-ABC group of transport companies) clearly established that behavior patterns among truckers puts them at high risk both of contracting and spreading STIs and HIV/AIDS.

Four STI/HIV/AIDS intervention centers operate at Calcutta Port Trust (West Bengal), Petrapole (West Bengal), Ichchapuram (Andhra Pradesh), and Raxaul (Bihar). The environment of the drop-in centers is friendly, with comfortable seating in familiar settings. Social workers initiate discussions on different health issues that are of concern to truckers. Each center is staffed by medical officer(s), male and female social workers, and counselors. Outside the centers, outreach workers constantly circulate in parking zones and interact with the truckers. It has been observed that truckers are no less comfortable with female than with male staff. In fact, they more readily accept women social workers.

Counseling is the most important element of all clinic activities and helps to motivate the truckers to comply and complete treatment. Counseling is done on a one-to-one basis. Clients can also participate in condom demonstration sessions as a significant proportion of the target population have never even tried to use condoms, although 92 percent know of their existence. Those who have ever purchased a condom constitute only 27 percent of the sexually active truck drivers and helpers. Many are afraid that the condom may burst inside the woman's vagina causing cancer. Also the truckers dislike the idea of using condoms, as thinking about risk and prevention before sex disturbs their emotional state. *Attempts to position condoms as protection against STIs have had little impact on the truckers. Therefore there is a need to position condoms as a means of enhancing pleasure rather than prevention.* Condoms are sold directly to the clients from the clinic as well as through non-traditional outlets such as tea and *paan* (betel leaf) shops, *dhabas* (roadside eating places), and general stores located at the parking zones and on the highways.

Repeat visitors make up a significant proportion (28 percent) of truckers coming to the intervention centers. Therefore, a formal training program will be conducted for selected repeat visitors that will enable them to function as peer educators on the highways.

The second phase of the project has included sex workers active on the highways as a secondary target population. This initiative faced some structural problems as sex workers come from adjacent communities and are not easily identified. Therefore center services have been extended to the entire community, with special emphasis on women suffering from STIs.

Participating Population

The first phase included truckers and eventually their families. The second phase of the project has included sex workers active on the highways as a secondary target population.

Principal Findings

Approximately one-third of truckers who come to the clinics suffer from STIs; other diseases also prevalent include skin diseases, chronic acidity, occasional fever, and colds. In the absence of any pathology testing facilities in the clinics or the nearby vicinity, STIs are treated syndromatically as recommended by World Health Organization. Rs. 15 (about 30 US cents) is charged for treatment that includes medicine for three days.

Truckers have started coming in for voluntary HIV testing which is offered by two of the four centers—(Calcutta Port Trust and Raxaul). Although the centers were originally started for male truckers only, over time services have been extended to their families. This was done because the truckers often bring other members of their family if they have ailments and it was thought that a community-based service could not refuse such requests.

It has been observed that truckers, in spite of their promiscuity on the highways, are very emotionally attached to their families. They feel concern for their wives and children and other elderly family members. Capitalizing on this, advertisements for condoms contain the message, *Parivaar Bachao* (save your family). Also, messages such as “condoms prevent the pain of STIs” are better understood by the truckers than the more generalized and distant, “condoms prevent AIDS.”

Success of projects such as these largely depend upon the motivation of staff and their level of skill. If projects are located at odd places, it may not be possible to employ qualified staff. Staff motivation and constant upgrading of provider skills need to be built in to project activities. Further, *although the quantity of condoms distributed has been very high, the figures do not necessarily reflect actual use.*

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Men on the Line

Organization

Talking About Reproductive and Sexual Health Issues (TARSHI)

Type of Activity(ies): Intervention

Talking About Reproductive and Sexual Health Issues (TARSHI) has operated a telephone help line in New Delhi since February 1996. The help line challenges the absurdity of talking about “choice” when we do not, and often cannot, talk about sex. The help line is free, available in Hindi and English, and confidential. Its anonymity is aided by the absence of a face-to-face interaction. TARSHI also engages in documentation and research, attempting to collate a database of the sexual behaviors, problems, questions, and the like described by callers. Research, however, is a secondary activity.

TARSHI's help line has three main components: information, counseling, and referral service. Operated by a team of trained counselors, supervised by a qualified clinical psychologist, all the counselors are full-time staff and receive a regular salary. Currently the counselors are all women, but in the past TARSHI has employed male counselors and found that this has not affected the response from male callers. Many men seem to find it easier to talk on the phone to a trained woman counselor.

TARSHI advertises its help line on the radio using jingles in Hindi. Of late their advertisements have also appeared on TV and they also put up displays at discrete places in major movie halls. These have proved to be effective in reaching out to all age groups. Newspaper and magazine articles about TARSHI also have spread awareness about the help line and added to its credibility. Approximately 30 percent of callers who report on where they got the TARSHI number say a friend told them or that they heard the number on the radio but were motivated to call when a friend told them about the service.

Participating Population

Men and women in urban Delhi (New and Old).

Principal Findings

As of May 1998 TARSHI had received more than 21,000 calls. Of these, approximately 80 percent were from male callers aged 10 to 70 years. These callers come from all socio-economic backgrounds but predominantly from the lower middle and middle classes. *It is important to note that TARSHI was created as a means of providing confidential information to women, but in fact is accessed primarily by men.* It is believed that this contradiction arises essentially because men can access telephones more easily and privately than women.

Overall concerns of callers include sexual issues and conventional reproductive health issues such as contraception and RTIs; abortion appears to be less significant. This clearly demonstrates men's need to be informed about how the body functions, how to deal with their sexual problems, and how to avoid conception and infections. Issues that frequently come up include sexual autonomy, sexual processes, reproduction, safer sexual practices, pleasure enhancement, contraception, STIs and HIV/AIDS. Other issues commonly brought up by male callers include: information about the body and its functioning, masturbation, nocturnal emission, sexual problems (e.g., erectile dysfunction, premature

ejaculation), foreplay, sexual acts and techniques, contraception, sexual pleasure enhancement, homosexuality, HIV/AIDS, sexual abuse, and infertility.

Men also feel free to ask questions about women's bodies and sexuality (breasts, female masturbation), but women callers do not ask as freely about men's anatomy or even their own. Men's concerns about sexual pleasure have more to do with their own pleasure than with the pleasure of their partners. Regarding contraception, both men and women seem to lack information about how conception occurs. A large number of men do not know how to properly use a condom. And while many have heard of "safe days," the information they have is generally inaccurate leading them to frequently have sex at the time the woman is most fertile!

Structural barriers faced in the operation of the help line include the limited number of phone lines currently available. Limited working hours also cause problems (callers can access the help line Monday through Friday, 9 am to 5 pm), and general lack of access to phones and/or privacy that inhibits people (particularly women) from calling. Another issue is the lack of good service providers to whom help line callers can be referred. Attitudinal barriers as defined by India's predominant social structure still deny sexual and reproductive rights to individuals.

TARSHI's help line is replicable. Efficacy, however, is contingent upon adequate training of counselors, high-quality supervision, good documentation systems, and, most importantly, a clear long-term vision rooted in a sound understanding of the relevant issues.

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Leadership and Gender Sensitization: A Four-Day Training Module

Organization

Society for Integrated Development of Himalayas (SIDH)

Type of Activity(ies): Study/Intervention

In conjunction with the Program for Appropriate Technology in Health (PATH), SIDH launched a “Men’s Involvement in Women’s Reproductive Health” (MIWRH) project by introducing a four-day training module on men’s involvement and redesigning the curricula of SIDH-operated, informal centers.

The MIWRH program had two components: a four-day training module on men’s involvement in women’s reproductive health and a holistic gender-sensitive curriculum for youth carried out in their informal centers. In addition, a five-day “training of trainers” program was developed for other NGOs and youth leaders. A training manual both in Hindi and English has been prepared but has not been published.

Participating Population

SIDH is a non-profit Organization working to improve education in the villages of Janpur block, Tehri district, Uttar Pradesh and has trained 250 youth leaders in 42 villages. SIDH has offered training of trainers to 12 organizations with an outreach of 732 villages. Only 15.4 percent of Janpur’s population is literate. The area is typified by a distinct cultural identity, which means that some of its problems are quite different from other regions within the same state. For example, until recently the practice of dowry was rare and even after getting married, women had the right to leave their husband and find another partner. However, many such practices, which may be considered empowering for women, are fast dying out under the influence of “education” and the assimilation of the majority culture.

Principal Findings

Compiling background information was a major aspect of the project and offered insight into specific conditions in the region. For example, depression and mental illnesses were found to be far more common among women than men, especially among married women. Men and women both identified health as a major problem, however, married women seemed to have more health problems than those who were unmarried. Women tended to express their problems symptomatically whereas most men identified their problems by naming the disease. Most women indicated a need for more help after childbirth as compared to during pregnancy, yet this is the time most men stay away. Men feel it is enough if they are around during childbirth.

Men and women also have different perceptions about children. More children mean extra expense to men and extra work to women. Women prefer to plan their families to spare themselves too much work and pain, both physical and emotional. On the other hand, most men feel that women can bear pain, therefore there is little men can do for their wives when they are ill. Family structures also have a bearing upon men’s role. *In nuclear families men help their wives but in joint families they do not.*

Problems encountered in implementing the project included:

- The project staff (two undergraduate young men and two young women) came with their own misconceptions, particularly in terms of human reproductive anatomy.
- Trainers were concerned that the participants were expected to make major personal changes and wondered whether SIDH had the capacity to provide the follow-up support that would be needed.
- Apart from being exploited by men, women are also exploited by other women in the family. In-depth exploration of the intra-gender relationships revealed the powerful role of the mother-in-law in supporting and implementing or inhibiting positive changes.
- Trainers felt that male participants were more receptive to the training when the presentation of women's problems was balanced with problems faced by men.

The lessons learned through this experience include:

- SIDH's young team members have evolved far more than the senior team, and *yuvati* (young girls) groups have been quick to learn and change. Hence youth has become the program's focus because learning is easier and quicker for them; the material is internalized and thus the impact is longlasting.
- Young husbands are frequently not assertive enough to cope with the pressures exerted by older women in the family.
- The popular belief that if a mother eats less and works hard it will help her to have an easy delivery still prevails.
- SIDH's male team members discovered that much information could be elicited from men during one-on-one informal conversations. Female staff discovered a different technique. They would sit quietly and listen in on the conversation of small, informal groups of village women who sit chatting outside their homes in the evenings.
- SIDH learned to question the authenticity of secondary data, especially from local government sources. Very often it was found to be grossly inaccurate because it had been fabricated in the office and not collected from the field.
- The most important lesson SIDH learned was that *providing space for men to articulate their problems can lead to greater openness in terms of their becoming more sensitive to women's problems.*
- It is important to create an atmosphere that is conducive for men to listen. They cannot do so if their energies are spent defending themselves or countering a perceived attack. Optimum listening will take place only when the atmosphere is non-threatening.
- Fear of alienation, isolation, and ridicule are the biggest problems men face.

A valuable insight came from a young male staff member when he wrote a poem entitled "To My Sister" in response to a poem titled "To My Brother" penned by a women staff member. These poems are about the personal feelings of men and women. In his poem, the young man pointed out the futility of anger as it would destroy all that was warm and wonderful. Instead he asked his "sister" to take his hand and teach him how to love and care so that together they would walk into a warm and compassionate world. To SIDH, this poem epitomized the height of this program's achievement as it is indicative of a shift to another paradigm – a paradigm where there is true gender sensitivity where one not only accepts but respects the other sex. Perhaps a distant dream today, it is certainly one to aspire towards for tomorrow.

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Involvement of Husbands in the Antenatal Care: Evaluation of Deepak Charitable Trust's Outreach Program

Organization

Deepak Charitable Trust (DCT)

Type of Activity(ies): Study/Intervention

In an effort to get more pregnant women to attend the antenatal care (ANC) clinics, *Pati Sampark* ("contacting husbands") was established in 1995 to try to motivate husbands to monitor their wives' clinic attendance and consumption of the iron and calcium supplements at the prescribed times.

The program is staffed by male and female outreach workers, and by trained midwives (*dais*). Female field workers identify pregnant women who do not attend ANC clinics, and then male outreach workers go to their homes to speak with their husbands and try to impress upon them the importance of antenatal care. A visit from the male outreach worker is seen by husbands as something "more formal" than visits by regular midwives, and thereby something of greater importance.

The *Pati Sampark* program was evaluated in 1996 by means of a study conducted in Nandesari, an industrial area 20 kilometers north of urban Vadodara. This region is home to some 200 operating chemical factories, interspersed with approximately 20 villages inhabited by a predominantly Rajput population which is quite conservative and imposes restricted roles on women. Open-ended

Almost 29 percent of men in the non-program group said they did not know any family planning methods, compared only three percent of men in the *Pati Sampark* group. The *Pati Sampark* program was also found to have had a small yet significant effect on men's views of their wives' nutritional needs during pregnancy

interviews were carried out with two sets of husbands: one that had been contacted by *Pati Sampark* outreach workers and another that had not been part of the intervention. Interviews sought to determine whether there had been an increase in ANC attendance by wives of men contacted by the *Pati Sampark* program.

Survey questionnaires were administered and in-depth qualitative interviews were carried out in 10 communities. Although the

interviewers attempted to conduct the interviews in private, usually neighbors or other household members such as the mother-in-law or the wife were also present for the discussion but did not take an active role. Eleven wives were also interviewed informally in order to determine the extent of differences in behavior and attitude between women whose husbands had, and those who had not, been visited by a male outreach worker. The program also wanted to see whether the men who were visited had communicated the information they had received from the health worker to their wives.

Participating Population

Structured survey questionnaires were administered to and completed by 113 men, 64 program participants and 49 non-participants. In-depth qualitative interviews were carried out in 10 communities.

Eleven wives were also interviewed informally in order to determine the extent of differences in behavior and attitude between women whose husbands had, and those who had not, been visited by a male outreach worker.

Principal Findings

The percentage of men who recalled whether their wives received ANC services was found to be consistently higher for men who had been approached by *Pati Sampark* outreach workers. Furthermore, almost 29 percent of men in the non-program group said they did not know any family planning methods, compared only three percent of men in the *Pati Sampark* group. The *Pati Sampark* program was also found to have had a small yet significant effect on men's views of their wives' nutritional needs during pregnancy.

Study findings

- Overall, a larger percentage of men in the *Pati Sampark* group were aware of the services delivered to women during ANC clinics held in the village than among non-participants.
- Men in the *Pati Sampark* group were much more likely to recall specific ANC services received by their wives such as provision of iron and calcium tablets, a blood pressure test, a hemoglobin test, and a tetanus toxoid vaccination.
- Men's knowledge of the purpose of ANC services as well as other information covered by the *Pati Sampark* program (such as safe childbirth, high risk pregnancies, and diet) was consistently more accurate among the *Pati Sampark* group than the non-participants. For instance, men in the *Pati Sampark* group were more aware of the purpose of giving a hemoglobin test and could conceptualize the link between iron tablets and "increased blood."

The evaluation supports the conclusion that the *Pati Sampark* program has been successful in increasing both interest and levels of knowledge about antenatal care among husbands approached by male outreach workers. This in turn has translated into a small but measurable increase in the attendance of their wives at antenatal clinics. It should be noted, however, that the actual effects of the *Pati Sampark* program may be diluted by the effects of other programs attempting to stimulate ANC attendance that were ongoing at the same time in the area. Therefore the evaluation report is perhaps most useful in illustrating the considerable variation in the styles, levels of knowledge, and behaviors of husbands with regard to their wives' pregnancies and health status. It also demonstrates that the attitudes and behaviors of men can change over time and can be influenced by well-trained outreach workers.

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Discussion

An important finding has been that health and wellbeing should be approached in a holistic manner, whereby the family is seen as a unit and a comprehensive package of health services is delivered according to the specific needs of the respective members of the family. Services can involve the management of a minor or major illness, the care of a pregnant mother or sick child, addressing the needs of adolescent youth or newly married couples, as well as other married couples and elderly members of the family. The underlying fabric of socio-cultural traditions and economic milieu has to be kept in mind while introducing any strategy. And lastly, but most importantly, “man” is always there and cannot be bypassed in the overall interests of the society, but should be included in efforts to build a true partnership with women counterparts.

Society for Education, Welfare and Action (SEWA)-Rural Research Team 1998

A number of themes and issues resonate across the experiences of the organizations documented here. Below we address some of these threads that are interwoven across the different program experiences. The organization of this material is based on a schema that emerged from an analysis of programmatic findings developed by the Council's interregional program on the involvement of men as positive partners in reproduction; a break-down of findings from partnership experiences as reported to date.

Women want and need the support and understanding of their partner(s) and family across a range of reproductive health subjects.

There were a number of very practical reasons reported by women in these case studies as to why they wanted their partners to be involved. For example, in many parts of India it is still thought that women should not eat too much during pregnancy in order to have a smaller baby and thus an easier delivery. When Centre for Health Education, Training and Nutrition Awareness (CHETNA) workers talked to women about the need to eat more and better food, they would frequently reply: “Why don't you give this advice about what I should eat to my family members. If I start eating what you suggest, my husband and mother-in-law will beat me”.

A number of NGOs found that the problem of sexually transmitted infections (STIs) also could not be addressed simply by providing women-friendly services. *Beyond physical access, the more crucial question is social access—women need to get the approval of their husbands and families in order to*

seek treatment. For example, as reported by Social Action for Rural and Tribal Inhabitants of India (SARTHI), as many as 50 percent of the women in a tribal area of Gujarat having STI-like symptoms, who had initially agreed to get themselves examined and treated, later backed out because male family members would not allow them to attend a health camp. In an urban setting, Community Aid and Sponsorship Program and Foster Parents Plan International (CASP-PLAN) realized that many women with STIs attending their Delhi gynecology clinic were not showing satisfactory improvement. A closer probe made it clear that these women required “partner compliance,” which was lacking. The women would lament: “*Aap hume to samjha dete ho, per hamare admi ko kaun samjayega* (you make us understand everything, but who is going to make our men understand?).”

In India disparity in age of marriage between women and men, added to the patriarchal structure of most families, means that men are making decisions about sexual behavior and contraceptive use. On the other hand, as documented in the studies among husbands carried out in Maharashtra and Tamil Nadu (Research Centre for Women’s Studies of SNDT Women’s University, Mumbai, and Community Health Department [CHAD] of the Christian Medical College in the south, respectively), *the very same men have been found to be poorly informed about the use of family planning in particular and reproductive health in general.* TARSHI (the telephone help line in New Delhi) has learned that a large number of men do not know how to properly use a condom. The Maharashtra study also revealed that many men consider abortion to be a spacing method and are unaware of the risks associated with the procedure and its potentially adverse effects on women’s health. And while many men have heard of “safe days,” the information they possess is generally not accurate, frequently leading them to have sex at the time the woman is actually at her most fertile.

Despite being the primary decision-makers, men almost uniformly feel that family planning is women’s business and the actual adoption of a method is her responsibility. According to TARSHI, questions about conception and contraception rank third on the list of concerns frequently expressed by men, but first among women callers. The work undertaken in Mumbai and Pune revealed that *while most men said that they did not want a child immediately after marriage, few took any action to prevent conception due to strong family pressure to produce a child as soon as possible.* It was only after the first birth that the subject of spacing could even be broached and some flexibility in the timing of the next pregnancy allowed.

Another reason that women want and need their partners’ support and understanding has to do with the prevalence of violence and coercive sex both within and outside of marriage. In 1996, M.E. Khan, then of the Council’s Delhi office,⁴ did a study on the extent of “Sexual Violence within Marriage” in rural Uttar Pradesh.⁵ Using qualitative techniques over a period of five months with 115 currently married women, the study revealed that not only were the women not prepared in any way for sexual intercourse, but that frequent incidences of sexual coercion occurred during marriage.

Husbands take as a “right” to have complete control over the body and sexuality of their wives. Any resistance on the part of women to submit to the sexual desire of their husbands could lead to violence.

⁴ M.E. Khan is currently with the Population Council office in Dhaka, Bangladesh.

⁵ Khan, M.E. et al. 1996.

This study also contradicts the general belief that women are subjected to sexual violence and rape largely by strangers or “outsiders.”

According to the authors of the study of men’s sexual health programs in a low-income section of Mumbai, “men’s perceived sexual inadequacy not only adversely influences the quality of family life but may also result in domestic and sexual violence.” The Family Planning Association of India (FPAI) survey of more than 2400 households in poor sections of Chennai revealed that coercive behavior, such as incest and sexual abuse, were prevalent among the population while the Child in Need Institute (CINI) reported that their focus group discussions with young girls revealed that sexual abuse and forced unprotected sex are fairly common.

Even though Mahinder Watsa specifically notes in his paper that “what women want are for their men to take responsibility to end alcoholism, gender-based violence, rape, and sexual abuse of women and girl children and to make sexual relations a shared pleasure,” it did not appear from the papers prepared for the workshop that violence and coercive sex were a focus within most of these activities. The editors therefore raise the question as to whether it is possible to address issues of sexuality and gender equity that underlie greater participation by male partners *without* specifically addressing these issues?

Lastly, a hotly contested issue, especially among some feminists, has been whether by involving men we are encroaching upon women’s domain and thus diverting scarce resources away from programs that benefit women?⁶ The key here is actually *how* men are being brought in. The process of “bringing men in” needs to be carefully considered so that in no way are we undermining the often precarious rights of women to control their own bodies and make their own decisions. However, if men participate *because of* a demand from women (as was the case in many of the activities reported here), then what we are seeing is a shift in the social construct that is being spearheaded by women themselves. Yet, it must always be kept in mind that *what needs to be protected at all costs is the right of each individual woman not to involve her partners if she so chooses—without the need of explanation.*

Men can be, and are interested in becoming, more supportive and involved in all reproductive health domains, specially where it concerns the welfare of children and families.

According to the case studies, many men indicated that they wanted to become sensitive to women’s special needs during pregnancy, childbirth, and lactation, but that they did not know how to go about

⁶ Nevertheless the Rural Women’s Social Education Centre (RUWSEC) found that working with men helped them understand the dynamics of gender relations better. Most importantly, bringing in men did not result in any “dilution in the existing focus on empowerment of women.” Instead men became more aware and more willing to seek help for their reproductive and sexual problems. In addition, the feedback from men’s programs helped RUWSEC improve their future activities for women (Sokhi, 1998)

it and feared facing social ridicule if they stepped outside accepted gender norms. Acting on this willingness to become more sensitive to women's needs before, during and after pregnancy, Deepak Charitable Trust started the *Pati Sampark* (literally 'contact the husband') program. An evaluation of the program revealed that it had contributed to an increase in women's attendance at antenatal clinics.

Also, in the project area where husbands were contacted, women were found to possess a more in-depth understanding of antenatal services as compared to women whose husbands had not been contacted. The project also found that through such an outreach effort, men significantly increased their understanding of what constitutes antenatal care and why it is important for their wives to participate (see tables below).

TABLE 2
Men's Knowledge of ANC Services Received by Their Wives

ANC Service	Men in <i>Pati Sampark</i> Group (N=64)		Men Not in Intervention (N=49)	
	Wife Received	Do Not Know	Wife Received	Do Not Know
Hemoglobin test	75.0%	18.8%	16.3%	79.6%
Blood pressure	84.4%	12.5%	30.6%	63.3%
Tetnus toxoid	98.4%	1.6%	55.1%	42.9%
Iron and calcium	98.4%	1.6%	63.3%	32.7%

In an attempt to increase hospital referrals for high-risk pregnant women, apart from personally contacting families, the SEWA-Rural sends postcards addressed to male family members where women have been designated as being at high risk. As a result, hospital referrals have increased and there has been a tangible increase among family members in the level of awareness of potential complications. About 65 percent of families that received the mailings were found to have responded to suggestions for appropriate care as outlined in the postcards.

TABLE 3
Men's Awareness of Family Planning and Birthspacing

Awareness About	Men in <i>Pati Sampark</i> group (N=64)	Men not in intervention (N=49)
Condom/Nirodh	82.5%	53.1%
Mala-D (oral pill)	58.7%	49.0%
Birthspacing	98.4%	77.5%
Value of 2-3 years between births	85.9%	63.3%
Family planning	96.8%	28.6%

SEWA-Rural's safe motherhood initiative also sought to involve male partners by scheduling field visits at times when men were most likely to be present. The overall success of this initiative is evidenced by a 40 percent increase in the number of men seeking out health workers to register their wives for early antenatal care and the fact that, on average, one out of three men now accompany their wives for visits to the hospital. There has also been a significant increase in the number of fathers who have started bringing their young infants to health centers for immunization.

The case study experiences also indicate that *children are a point of converging interest between men and women in many settings*. For example, CHETNA found that men took a real interest in growth monitoring sessions for children, so they began providing additional information to men on child care during these sessions and revamped their “parents’ camps” to welcome fathers’ participation. Similar experiences were encountered by other programs as well; for SEWA-Rural, a comprehensive health approach aimed at improving the wellbeing of the whole family was found to be effective in their work in a tribal region of Gujarat.

In West Bengal, peer educators working with CINI reported that young, newly married men *were* willing to listen to discussion of new and gender-sensitive ways of approaching women’s health but were paralysed from acting on what they were learning due to immense social pressure from elders—particularly older women. CHETNA also found that even when community men became more open to gender equality, they reported facing criticism from family members—sometimes including their wives—if they attempted to assist in housework or take on some of the woman’s responsibilities. Likewise SIDH found that young husbands frequently were not assertive enough to cope with the pressures exerted upon them by older women in the family.

Health care providers and community outreach workers usually need additional, specialized training and support before they can address the gender and sexuality issues that underlie greater involvement of men in reproductive health care.

Service providers and outreach workers, as well as researchers, are key to successful execution of initiatives to positively involve male partners. An examination of the studies and interventions profiled here reveals that *very special training was required before workers could even begin to address the issues of sexuality and gender equity that underlie successful efforts to include men in reproductive health programs*. Across programs and with both male and female workers, it was found that a range of concerns and apprehensions regarding sexuality, pregnancy, abortion, and infertility had to be addressed.

SEWA-Rural’s experience working with newlyweds in rural Gujarat revealed that while most young couples were eager to learn more about reproductive health matters, it was the health workers who had trouble shedding their own inhibitions and preconceived attitudes about sexual behavior. Multiple, ongoing training of the same group of workers, covering only a few topics per session, was found to be the most effective way to begin overcoming these hurdles. Ultimately their teams of male and female health workers have proved to be good role models in the community. CINI also reports that some of its health workers have actually told them that their relationships with their own spouses have improved, based upon what they have learned.

Before beginning their interventions, SARTHI concluded that, “staff members needed to overcome their own internal barriers and increase their openness and sensitivity to sexual matters if their efforts were to succeed.” They also found that training that is experiential and participant-centered was more effective than clinical or topic-centered approaches. Several groups found techniques such as body mapping and question boxes a great help in facilitating openness and comfort among program participants when dealing with sensitive topics. And based on their intervention with truck drivers in West Bengal, Bhoruka Public Welfare Trust emphasized that success in projects such as this one is dependent upon both the motivation and skill level of staff which, in turn, need to be strengthened through ongoing support and upgrading of provider skills. The experience of K.E.M. Hospital Research Centre, Pune, in carrying out research on male involvement was that all their researchers required special training before they were comfortable talking about sexuality.

From the experiences documented here, it does not appear that the sex of a worker had much impact on how well they were able to work with men. In fact, both TARSHI (the New Delhi help line), and the Calcutta truckers intervention, found that men actually indicated a preference for talking to women. K.E.M. study found that even with special training, some of their male researchers lacked the confidence to ask men questions about their sexual behavior, while CHETNA concluded from their work in Gujarat, *that it is better to have no male trainer than to have one who is insensitive to gender issues.*

Age differences between service providers and their constituents in the community were, in several cases, noted as a barrier to effective communication. Thus at SARTHI, more senior staff were employed to sensitize older men during *vadilon ni baithako* (meeting of elders). Similarly, SIDH found it easier to work with a younger staff as they were essentially addressing a younger audience. Several groups also noted that class differences between trainers and trainees, or workers and clients, only added to the difficulty in addressing sensitive topics.

Timing, location, and structure of interventions can encourage or discourage partner involvement

Within the material presented here, the importance of time and location emerge as critical elements in effectively reaching men. SEWA-Rural found that care must be given *where* and *when* activities and services are held and, according to CASP-PLAN, even the season of the year has to be taken into account. Several organizations noted the importance of convenient clinic hours and the timing of field visits as being critical to successfully reaching men. In two instances—the experience of setting up a male clinic in Chennai, as well as in rural Uttar Pradesh—providing separate space or separate times when men could access services was considered to be an important variable leading to program success.

Concerned about preventing STIs, including HIV/AIDS, the Bhoruka Public Welfare Trust established an intervention program for truckers at strategic points along major highways. These drop-in centers/clinics were designed to look like resting places rather than medical clinics. Services included treatment of STIs, condom distribution, HIV testing, information, education, and counseling. The project found that despite their promiscuous behavior, most truckers showed great concern for their families. In fact *they began bringing their partners and other family members for treatment of STIs, as well as general health care* because they felt that they were accepted at the centers and that the quality of services provided was high. The project also showed that to bring about a reduction in infections, staff also needed to reach sex workers in the surrounding area. Since it was often difficult to identify which women were, in fact, engaged in sex work, the Trust decided that clinic services should be made available to the entire community.

A number of projects cited the fact that it is often difficult to get men to come together in groups and then to keep their interest alive over a period of time. Some men also appeared to be particularly resistant to participating in discussions where women were present (as participants not facilitators). The Survival for Women and Children Foundation (SWACH) found that men were more candid in talking about the behavior of men from other groups or communities than their own; however, candor, coupled with sufficient prodding, eventually brought forth some discussion of personal behavior.

SIDH concluded that providing space for men to articulate their own problems could actually lead to a greater openness on their part in terms of being more sensitive to women's problems. And in the process of sensitizing male youth about the unequal position of women vis-à-vis men, SIDH found that any attempt to talk about women's issues made men defensive. So after much trial and error, they realized that *the young men needed a non-threatening and safe place to articulate their problems first, before they could begin to listen with sensitivity to women's problems*. Otherwise much of their energy was spent countering what they perceived as an attack on them.

Drawing upon his prolonged work with adolescents, Watsa pointed out that *to be successful, sexual health programs must be realistic and need-based; values, interpersonal relationships, and decision-making need to be stressed*. SIDH's experience shows that it is important to address these issues through feelings and personal experience rather than through an intellectual approach.⁷ CASP-PLAN and SEWA-Rural both observed that changing attitudes takes time and patience and, in SIDH's experience, it appears to be easier to see attitude change among young people than adults.

⁷ The importance of feelings and personal experience became apparent during the workshop held at Nepal itself. Media presentations were given by three young men—two filmmakers and one actor. The filmmakers were embarking on the production of documentary films on masculinity in the subcontinent and the actor starred in a recently released film, which was shown at the workshop, called *The Pregnant Father*. Another short clip was screened in which the two filmmakers were shown participating in a discussion of what it means to them to be men and how, as men, they have to conform to social norms that they themselves do not feel comfortable with. These two men offered a very personalised account of their journeys through manhood and this moved many participants to rethink and broaden their own views on issues of manhood. In subsequent small-group discussions, this contributed to much more thoughtful and practical outlines of what men would do next in their own sphere of influence. The soul-searching that occurred can be summed up by one participant's comments: "Tossing and turning, I could not sleep thinking about [the film narratives]."

Men have reproductive health needs of their own which are rarely addressed

Most of the experiences included here share one finding in common: many Indian men are ignorant not only of their bodies, but also about how their sexual behavior affects their own health let alone that of their partners. It seems that in India many men do not necessarily attribute their sexual health problems to interpersonal contacts. Rather they assess their problems in terms of prevailing notions of maleness. Studies of men's sexual health, such as that done in Mumbai by researchers of the International Institute of Population Sciences, report that notions of maleness are centered around the quantity and quality of semen (*virya*, in Sanskrit, literally meaning vigor and strength) and the accumulation of heat (*garmi*). Men believe that the loss of semen is debilitating, both physically and spiritually, and that the quantity of semen each man possesses is limited. Therefore, the wasting of semen through masturbation is the source of great insecurity and guilt for many Indian men. In some cases, men feel it is actually better for their health if they go to a sex worker rather than "waste" their semen. What is daunting is SIDH's observation that women also share these belief: "Men get their strength from *virya*. We must take our share of their strength." They further observe, "condoms will prevent the flow (and therefore the transfer of the strength) to us."

Men interviewed as part of the research reported serious concerns about the size and shape of their sexual organs and their ability to perform sexually. Since masculinity is often defined in terms of "performance," there are also apprehensions about the use of male contraceptive methods (vasectomy and condom) that they see as holding the potential to obstruct or restrict performance, as well as reducing the quantity and/or quality of *virya*. Anxiety about the ability to "perform" causes many young men to have unprotected sex in anticipation of marriage. Men working away from their spouses (such as truckers) often feel the need to reduce the build up of *garmi* by engaging in high-risk sexual behavior. Men's perceptions of their sexual problems are, therefore, significantly different from biomedical reality. This means that *overcoming myths and misconceptions and imparting not only knowledge but comfort with one's sexual identity is a necessary precursor to responsible sexual behavior and can be approached in a variety of ways.*

One question that is frequently raised when discussing the subject of greater involvement of men is, "Is it necessary to provide male-only services?" Parivar Seva Sanstha (PSS), an affiliate of Marie Stopes International, undertook community research and found a high degree of unmet demand for male reproductive health services. As a result PSS started a separate "male-only clinic" in Chennai, but one offering "integrated" health care rather than a focus solely on family planning or treatment of STIs. The men's clinic is also located in close proximity to the existing women's clinic because it was felt that this would help to create a positive image of integrated family care. The FPAI concluded from their Sexual Health Project, carried out in Chennai, that services for men should be offered in a separate room or at different hours than women's services.

As in many parts of the world, men's lack of familiarity with and inability to correctly use condoms was noted in several of the case studies. However, it seems that in the Indian context (unlike most other

settings) condoms are perceived as a family planning method, not as a means of preventing the spread of infection. This is because condoms have been widely promoted as a contraceptive method by the Indian family planning program for several decades. Therefore, Indian men are more likely to use a condom with their wife than with other women. The Bhoruka Public Welfare Trust adds an important caution based on their experience that is often ignored in the rush to distribute condoms: *it is not possible to measure actual condom use solely by counting the number of units distributed.*

Early marriage, specially for girls, is the norm in India underscoring the need to foster better, more equal supportive relationships between young men and women before, in transition to and in early marriage.

Despite rising age at marriage, most Indians living in rural areas still marry young—particularly girls. So *most adolescent girls in India are, in fact, married.* Further, for many couples childbearing tends to be completed by the time a woman has reached her mid-twenties. In this context, it is not surprising that newly married couples were seen by many of the NGOs documented here as an important audience for reproductive health information.

A number of organizations profiled here have begun to offer programs designed specifically for newlyweds. In Vellore (South India), CHAD began holding bimonthly meetings for newly married couples. About 10-20 couples attend these meetings where they are given a kit containing condoms and a calendar for use in calculating the “safe period.” This approach has now been taken up by the government of Tamil Nadu as part of their Integrated Nutrition Program. In rural Gujarat, SEWA-Rural, holds meetings with newly married couples alone and then in conjunction with their elders. They also hold occasional *melas* (fairs) for newlyweds featuring various IEC materials and gift packs containing contraceptives.

Several programs are also trying to reach young people *before* marriage. Contrary to popular thinking, research is showing that unmarried adolescents are sexually active in rural as well as urban areas.⁸ At the same time, the studies reported here found young people to be ignorant about their own bodies and to lack knowledge about sexual behavior. CHAD’s research team in Vellore also learned that it is difficult if not impossible for unmarried young people to procure contraception.

NGO experiences, particularly those of CINI and CHETNA, as well as FPAI, indicate that while boys appear to know more, often much of the information they possess is highly inaccurate. These observations are also substantiated by research undertaken by the K.E.M. Hospital in Pune as well as in the work of Watsa on adolescents, showing that both boys and girls strongly desire information on sexual issues.

As observed in the K.E.M. study, most of what girls are told about menstruation and sexuality is in the form of proscriptions, rather than information. They also found that while *married women* specifically asked, “why should boys know about menstruation or pregnancy,” *unmarried girls* felt it was vital for boys to receive this information. As one girl noted, “boys must know about these things so they will be

⁸ (Watsa 1993; Goparaju 1993; Savara and Sridhar 1994; Jejeebhoy 1998; Sharma and Sharma 1997; Khan et al 1998). According to one estimate, 1 in 4 to 5 adolescent boys are sexually active before they are married (Jejeebhoy 1996). These figures are not very different from rural findings (Pelto 1999).

more caring towards their own wives.” Family Welfare Education and Services (FWES) found “letterboxes,” wherein questions can be asked anonymously, to be an effective tool in programs aimed at adolescents in Gujarat as it circumvented embarrassment for teachers and pupils alike. They report that letterboxes are now in use in more than 55 educational institutions in their project area, and that they have also established two local health centers that offer services for adolescents that they see as positively affecting the level of knowledge and attitudes. Answering basic questions about sexuality and sexual behavior appeared to pave the way for adolescent boys to begin asking questions about male involvement with children and other partnership issues and to seek information about the reproductive processes of girls as well as to express concern for their own wellbeing. For girls, sex education resulted in their viewing sex as more than just a means of procreation but as a means of sharing love. This in turn started them thinking about other possibilities for “sharing” in married life. Another intervention in Chennai found that sharing what is learned in boys’ groups with girls, and in girls’ groups with boys, was an excellent way to encourage greater openness about sexual issues.

A valuable insight came from a young male staff member when he wrote a poem entitled “To My Sister” in response to a poem titled “To My Brother” penned by a women staff member. These poems are about the personal feelings of men and women. In his poem, the young man pointed out the futility of anger as it would destroy all that was warm and wonderful. Instead he asked his “sister” to take his hand and teach him how to love and care so that together they would walk into a warm and compassionate world. To SIDH, this poem epitomizes the height of this programme’s achievement as it is indicative of a shift to another paradigm—a paradigm where there is true gender sensitivity where one not only accepts but respects the other sex.

Society for Integrated Development of the Himalayas (SIDH) 1998

The experience of CINI, SEWA-Rural, and CHETNA have all made clear that while there was often initial resistance within communities to providing sex education to young people, particularly girls, if the organizations were well established and trusted, this resistance could usually be overcome. Urban and rural interventions reported by FWES, as well as by Mahinder Watsa, indicate that *confidentiality and anonymity in accessing information and care, along with patience and persistence in handling, are needed to overcome barriers to working with young people* as is the need for continuing and ongoing contact. When this is the case, they have found that family planning and reproductive health topics can be approached successfully among youth and appear to result in some instances of changed behavior.

Looking Ahead: Where Do We Go From Here?

The experiences documented here reveal that the importance of male involvement within reproductive health programs is truly beginning to be understood and addressed at the grassroots level. A major concern highlighted at the close of the workshop held in Nepal was how to go about building on what has been learned so that there is impact within the mainstream of service delivery.

The Need to Measure the Impact of Interventions to Encourage the Positive Involvement of Men in Reproductive Health

An important goal of this publication is to stimulate additional field-based research and interventions that can further elucidate the appropriate circumstances and best means to engage men as supportive partners. The hypothesis of this work is that fostering positive partnerships is supportive of individual rights and will assist in the achievement of program goals across the entire spectrum of reproductive health services. If we are to seriously influence the design and implementation of programs and policies, we must be able to present evidence demonstrating when and how involving marital and sexual partners is, in fact, important if not critical to supporting women's reproductive health and choice and achieving program goals. The arguments for reaching men are far broader and more encompassing than targeting men as contraceptors or identifying them as impediments to women's use of family planning. Adding program elements responsive to men's needs as individuals and partners should not be considered an "add on" (and thus potentially a burden to siphon off resources to other programs), but potentially as a vital strategy to advance program objectives such as better-informed, safer sexual practice, better-utilized antenatal and postpartum care, or more immunization coverage of young children.

In the absence of systematic baseline and post-intervention data, it is difficult to ascertain to what extent most of the NGO interventions presented here have resulted in attitudinal, let alone behavioral, change. Several of the NGOs admit that it is difficult to identify to what extent change resulted from their activities alone or in combination with other initiatives taking place in the community. For this reason, it could be beneficial to establish linkages between researchers and grassroots NGOs so that early in the development of new programs, the means of ascertaining their effectiveness could be built into the program design. The results of such collaboration would benefit both groups, and results of well-designed and well-executed studies would be of great value in convincing program managers, policymakers, and governments that including a focus on men will enhance, rather than distract from, achievement of the overall program goals that aim at betterment of health in general and reproductive health in particular for all.

Most NGOs active in the field do not have many opportunities to undertake research as they must devote their time and resources to training and to delivery of services. The Deepak Charitable Trust

was able to collect both quantitative and qualitative pre- and post-intervention data (albeit from a relatively small sample) and thus demonstrate a positive impact of its efforts to improve the health-seeking behavior of pregnant women when their husbands were contacted as compared to when they were not. However, they were able to undertake this study because of the assistance of a graduate student from Johns Hopkins University with funding from the British High Commission in Delhi. SARTHI too has been able to utilize the services of outside researchers to help with both assessing local knowledge and project evaluation.

The Importance of Engaging the Public Sector and Moving to Scale

However limited their efforts may be, NGOs have been in the forefront in terms of addressing men as a constituency. But because of the very nature of the work, their reach in terms of population and geographical spread remains restricted. The challenge is how to encourage more of these rich NGO experiences while, at the same time, finding the means to incorporate what they have learned in the design and implementation of public programs .

In most settings, including India, only governments have the resources and the outreach to provide health services to the majority of their people. NGOs can offer their help, but the widespread implementation and upscaling of interventions ultimately still depends upon political will and support. To take one example, if men are to be welcomed, if not encouraged, to accompany their partners for antenatal check-ups, delivery, and postpartum care, employers must be encouraged to provide parental leave and public clinics must not only create a welcoming atmosphere, but offer services at times when fathers are available (evenings and weekends). Yet, in his background paper prepared for the Workshop held in Nepal, M.E. Khan noted that, "while health services in India have undergone a paradigm shift, encouraging men's involvement in such programs is by no means a priority." Rather, the paradigm shift is reflected in the current emphasis on decentralized decision-making that puts greater responsibility on state governments. At the national level, Khan concludes, "Initiatives [to involve men] are confined to introducing non-scalpel vasectomy and promotion of condoms."

Unfortunately, the current tendency on the part of many governments is to expect the NGO sector to shoulder all these responsibilities. In the case of India, policy documents mention delegating tasks to NGOs that the government system, "is not in a position to even attempt."⁹ But even if this candid admission is to be interpreted as a genuine confession of inadequacy and a desire to involve the NGO sector as a partner, potential danger lurks in such a proposition. It could be interpreted that what is really being said is that any efforts to change attitudes, to erode the patriarchal bases of structures and to spearhead social change are not the State's responsibility. Time and again it has been demonstrated that efforts, however sincere, cannot be sustained unless there is an institutional framework to support them and only the government has the legitimacy and power to do so on a wide scale. Therefore joint efforts drawing from each other's strengths is a clear necessity.

⁹ Government of India, 1997.

An important program goal for the year 2000 and into the next century is to find ways to transfer what has been learned by these small-scale efforts to the public sector programs that provide services for the largest sector of the population. As was apparent in the workshop held in Nepal, it is not that government programs are not interested: In his concluding remarks, the Director of the Family Welfare Project in Andhra Pradesh, for example, singled out a number of ideas from the workshop that he planned to implement in his district. More often, the difficulty is in finding ways to facilitate collaboration that take into account the often limited resources of most grassroots programs. The Principal Secretary of the Government of Madhya Pradesh summed up the situation, noting that the government did not have the expertise to change and needed help. He called for more networking and for players from all sectors to work together.¹⁰

¹⁰ Population Council, New Delhi, 1998.

The emergence of this kind of collaboration can already be seen in a few of the case studies. In Maharashtra, the Foundation for Research in Health Systems (FRHS) has been working with state government officials to propose interventions based on the studies they have carried out. They have explored the possibility of including men in existing reproductive health services and providing education for adolescent males within a government program that provides tetanus inoculations for 16-year-old boys. (They also proposed providing first-level management of infertility at the level of primary health centers, but this was rejected by government officials who felt that such services would be little used or misused in the rural areas—an interesting stance given that *India Today* magazine recently ran a feature on increasing levels of infertility among Indian men.)¹¹ In Vellore, the state government of Tamil Nadu has replicated the meetings of newly married couples developed by CHAD as part of its Integrated Nutrition Program in the area.

Conclusion

While most NGO initiatives so far have been concrete activities involving men in practical matters related to reproductive health, the ultimate goal is about changing an unequal gender equation. It is about social change within the wider realm of gender equity. Freeing men from gender stereotypes will not only open up new spaces for them, but will also help women to expand their capabilities. It will also result in happier, healthier women, men, and children.

¹¹*India Today*. 31 January 1994. .

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Watsa, Mahinder C. 1993. "Premarital Sexual Behaviour of Urban Education Youth in India," paper presented at the Workshop on Sexual Aspects of AIDS/STD Prevention in India. Bombay.

Location of nongovernmental and other research organizations which documented their experiences.

Location	Nongovernmental /Research organization
Ahmedabad	: Foundation for Research in Health Systems (FRHS) : Centre for Health Education, Training and Nutrition Awareness (CHETNA)
Bharuch	: Society for Education, Welfare and Action (SEWA) – Rural
Calcutta	: Boruka Public Welfare Trust
Chennai	: Family Planning Association of India (FPAI)
Gandhinagar	: Family Welfare Education and Services (FWES)
Mumbai	: Research Centre for Women's Studies : International Institute for Population Sciences : Council for Sex Education and Parenthood
Mussoorie	: Society for Integrated Development of Himalayas (SIDH)
New Delhi	: Community Aid and Sponsorship Program and Foster Parents Plan International (CASP-PLAN) : Parivar Seva Sanstha : Talking About Reproductive and Sexual Health Issues (TARSHI)
Panchkula	: Survival for Women and Children Foundation (SWACH)
24 Parganas	: Child in Need Institute (CINI)
Pune	: King Edward Memorial Hospital Research Centre
Taluka Rajpipla	: Action Research in Community Health and Development (ARCH)
Vadodara	: Social Action for Rural and Tribal Inhabitants of India (SARTHI) : Deepak Charitable Trust (DCT)
Vellore	: Community Health Department (CHAD)

Additional Papers

This publication has discussed the papers (prepared for the workshop in Nepal) that focused on field research and intervention. This is not to underplay the usefulness of other papers and presentations, some of which have been noted in the above discussion. A list of these works along with other reports about the workshop are listed below and are available directly from the Population Council's South and East Asia Regional Office.

Kaza, R.C.M. 1998. "Vasectomy Revisited," paper presented at the Population Council New Delhi Workshop on Men as Supportive Partners in Reproductive and Sexual Health. Kathmandu, Nepal. 23-26 June.

Khan, M.E. et al. 1998. "Involving Men in Reproductive Health – Policy, Action and Future Challenges from Programme Perspectives, " paper presented at the Population Councils New Delhi Workshop on Men as Supportive Partners in Reproductive and Sexual Health. Kathmandu, Nepal. 23-26 June.

Pachauri, Saroj. 1998. "Locating Male Involvement within a Reproductive Health Framework," paper presented at the Population Council New Delhi Workshop on Men as Supportive Partners in Reproductive and Sexual Health. Kathmandu, Nepal. 23-26 June.

Verma, A., Shagufa Kapadia, Shubhada Kanani, N. Rajaram, Sandhya Joshi, P.V. Kotecha, Urvi Shah. 1998. "Men's Roles and Responsibilities for Women's Health," paper presented at the Population Council New Delhi Workshop on Men as Supportive Partners in Reproductive and Sexual Health. Kathmandu, Nepal. 23-26 June.

Visaraia, Leela. 1998. "Role and Responsibility of Men in Reproductive Health: Evidence from India," paper presented at the Population Council New Delhi Workshop on Men as Supportive Partners in Reproductive and Sexual Health. Kathmandu, Nepal. 23-26 June.

Population Council, New Delhi. 1998. "Men as Supportive Partners in Reproductive and Sexual Health – Narrating Experiences". Background Material, Kathmandu, Nepal, June 23-26.

Population Council, New Delhi. 1999. "Enhancing Male Involvement in Reproductive and Sexual Health," Workshop Report. Himachal Pradesh. 11-12 September.

Population Council, New Delhi. 1999. "Reaching out to Men as Supportive Partners in Reproductive and Sexual Health," Workshop Report. Mumbai. 24-25 February.

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