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Reproductive Health Issues: Focus on Men

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Introduction

Most family planning and reproductive health researches and services in India, as elsewhere, target women, that too ever married women in reproductive ages. Consequently, these services as well as researches have not addressed a large number of issues concerning men [2]. Ironically the Indian family planning program, which witnessed a massive response from men to accept vasectomy, took a complete U-turn during the 70s and vasectomy was replaced by tubectomy and laparascopy [3]. It has often been argued that probably, it is easier to reach women than men. Particularly, from an intervention standpoint, one might anticipate that it would be easier to motivate changes in health care behavior among women then among men. A very high maternal mortality and poor health status of women and children also necessitated most health programs on reduction of maternal and child morality, and therefore left the men out of focus. In the 1970s, following the Bucharest conference, integrating family planning with the maternal and child health was strongly emphasized.

While these were welcome changes in the overall strategy for promoting the welfare of women and children, the criticism which comes in the way of family planning and health programs is that these have ignored the ground realities of reproductive behavior - family structures and gender relations. It needs to be recognized that women, particularly in developing economies, are economically and emotionally dependent on their male partners and find it difficult to raise issues such as safe sex (Gordon and Kanstrup, 1992). In a patriarchal system men have a strong hold over women's reproductive lives and goals. The rising rates of STDs and HIV infections have also made it clear that the male involvement is essential, as marginalizing them would be harmful to the women's health, as well.

The reproductive health package of International Conference on Population and Development (1994) held at Cairo (ICPD), aims to provide people with a satisfying and safe sex life, capability to reproduce and the freedom to decide if, when and how often to do so. The ICPD also stressed the need to encourage and enable men to take responsibility for their sexual and reproductive behavior and their social and family roles (UN, 1992, para 4.25). Thus, male involvement does

not just mean promoting the use of male methods of contraception. It refers to supportive role to their families, to promoting gender equity, girl's education, women's empowerment and the sharing of child rearing activities and sexuality.

The behavioral and psycho-social aspects of reproductive health issues concerning men, revolve around (i) involvement of men in contraceptive program, (ii) assuming greater responsibility and participation in all matters related to conjugal relations, and (iii) promoting greater understanding over male sexual health problems and its management.

Family Size and Contraception

The contraceptive programs have very little to offer men in terms of modern contraceptives, other than condom and vasectomy. It is another matter whether men would have "elected to use, for example, long acting but reversible medical methods when thus far they have not embraced those that involve little or no actual risks to their health" (Sanjeev Kumar, 1996). Studies show that men want more children than women and also that men make ultimate decisions about the use of family planning methods and size of family (WHO, 1994-95). Men are likely to approve of contraception for others but very few are likely to approve of contraception for personal use or for use by their wives.

Resistance to family planning comes from the typical men's belief system that family planning acceptance promotes promiscuity among their wives, causes infertility, leads to deformed children, has serious side effects, and more significantly undermines man's authority as the head of the household. Negative attitudes of service providers is also one of the key reasons as to why they do not readily practice family planning (WHO, 1994-95). It is traditionally assumed that men are difficult to reach and that they are resistant to changes in their reproductive attitudes and behavior. Lack of political commitment and inadequate policies are some other reasons quoted for thus far poor involvement of men in the contraceptive programs. The major jobs obstacles, however in expanding the male involvement, in family planning programs revolve around socio-cultural considerations, which affect both the men and the change agents.

Yet another reason for the low participation of males in family planning programs is the continued high value attached to motherhood. Despite increase in women's education and their enhanced participation in the work force, motherhood continues to be a cherished and valued goal for women, whereas men continue to take their fatherhood for granted. Men to consider being, a father an important part of their life. But the child rearing activities are still carried out by women. The difference in male and female child rearing responsibilities also leads to differences in use of contraception (Population

council, 1994). It is hypothesized that the limited role of men in child rearing leaves them with little incentives or motivation to use contraception. Very few studies have actually looked into men's attitudes about contraception, pregnancy and child rearing and also into the possible ways of changing their resistance.

Are men really resistant to change? Supportive male partners have been shown to encourage the usage of contraceptives. O'Hare et al., (1985) in their survey in Jamaica noted that men were reluctant or possibly could not envisage a more active role in reproductive health care. Inclusion of men in counseling programs has been shown to result in an increase in contraceptive usage among their wives, hinting that men are susceptible to change initial bias against family planning (Mbiz and Bassett, 1996). Surveys in many countries have shown that most men want more information on family planning. Even in patriarchal societies in Kenya, Mexico and Pakistan, men obtained vasectomies when properly promoted (Danfortli and Jezowski, 1994). Inclusion of males in family planning programs in Nigeria was reported to enhance the overall performance of the programs (Orobaton, 1993). It is essential that fathers are provided with the motivation and information on sexuality and contraception requirement to guide their sons in their transition from adolescence to adulthood (Mundicro, 1995).

It has often been argued that there is a need to educate men on the socio-economic benefits of family planning, which has an appeal among men [4] as against the health benefit of family planning, which has a greater appeal among women. The foundation for integrating the family planning with MCH program was laid on, this latter arguments perhaps to make family planning more palatable. While both the approaches are laudable so long as they achieve the intended goals, what is needed is to forge a greater degree of partnership between husband and wife, where men not only lend support to their partners' needs and choices but also own up the responsibility for the consequences of their sexual and reproductive behavior.

Demographers have made little contribution to this field except using inter-spouse communication as a variable to determine the family size.

Conjugal Relations

The social science domain has enriched literature, which provides glimpses of the important role men play in the household or conjugal matters. Demographic literature on the other hand has only concentrated upon inter-spouse communication for family planning and fertility related issues. But then, inter-spouse communication on family planning may not show/demonstrate the conjugal life.

Number of studies have shown that women on their own take the decision of getting sterilized without the knowledge of their spouses, which reflects poor inter-spouse communication and men's negative attitude towards family planning. In a patriarchal society, conjugal relationship depends upon perceived notion of man about women, i.e., his wife. There is a dearth of literature on men's perceived notion about women, which to a great extent is related to the socialization process, and this needs to be examined. Conjugal relationship is marred by violence and dominance, by men over women. In one of the recent studies among men in Uttar Pradesh, it has been found that about one-third men reportedly mistreat their wives (Narayana, 1996). Mistreatment of wives could be in different forms such as shouting or yelling, slapping or pushing, pinching or kicking and the use of stick or weapon. What is more important is that the extent of family violence has not undergone change over a period of time between generations. The study has also examined the men's attitude towards women and found that men perceive that their wives should always respect them and verbal insults and physical beating should be employed if wives do not comply with the instructions given by the husband and elders.

A belief seems to persist that violence and dominance are somehow inherent to men's nature whereas an aggressive impulse in females is discouraged. It has been, however, argued that, although there appears to be some biological basis for men's greater propensity towards Violence, this potential can be either reinforced or largely eliminated depending upon socialization. The Family violence to a large extent is because of "masculine mystique" that encourages toughness, dominance and extreme competition at the expense of honest emotion, empathy and communication.

Sexual violence within marriage is yet another subject, which is tabooed and needs to be studied. Khan et al., (1996) have shown that husbands take complete control over the body and sexuality of their wives. The responses from women respondents reveal a frequent sexual coercion within marriage. The social structure perpetuates this and any resistance on part of women to submit to the sexual desires of their husbands could lead to violence. In the study by Narayana in Uttar Pradesh, of all the men respondents, 28 percent said that they had sex with their unwilling wives and of those who had sex with their unwilling wives, 23 percent physically forced their wives to have sex.

Sexuality and Sexual Behavior:

Family planning steadfastly ignored the issue of sexuality and gender relation's which is the underlying cause of virtually all of the behaviors and conditions addressed by reproductive Health. One of the critical categories of differentiation

is gender. Girls, boys, women and men not only have different bodies, but they are also socialized into different gender roles that significantly influence their sexual behavior. It is this society which provides the context in which behavior is shaped. It is in fact the tremendous pressure of traditional gender role ideologies, which create individual's assumptions about his or her own sexuality (Amuchastegni, 1996). Information on sexual norms comes primarily from the family and most popular culture.

Emphasis on male responsibility for safer sexual practices and use of condom came into the picture as a result of an alarming growth of AIDS and HIV infectious. Sexuality means total sexual make-up of an individual, covering, the physical aspects, attitudes, values, experience and preference (Bhende, 1993). Sexual behavior varies from individual to individual in the social context and within different societies. Knowledge about the sexual behavior of men and women is severely hampered by lack of data. However, based on available information from small-scale studies some salient features on sexual behavior can be identified. Studies on STD/HIV/AIDS shows that males involve in earlier sexual activity than females and the propensity for multiple partners is also more among them. Moreover, the risk factor is more in males as they visit CSW (commercial sex worker) and the aspect of migration of men away from home, makes it more pertinent to involve men in reproductive health packages (Orobaton, 1993).

Most studies on sexual behavior conducted during the last few years suffer from methodological inadequacies yet they provide useful insight into the sexual behavior of Indian men. Although Indian society in general disapproves of the premarital and extra-marital sex among both men and women, it is more tolerant towards deviations in the male sexual behavior than in women. In fact the opportunities for the pre and extra marital sexual adventures are greater for men than for women (Nag, 1996). Studies that have been conducted so far seem to suggest a more liberal attitude of men and women towards pre marital sex than what one would expect in traditional Indian society (Watsa, 1990; Rangaiyan 1996; Nag 1996).

To a large extent the permissive attitude is also reflected in the experience of actual premarital sex among-college students as revealed by a few studies. Sehgal et al, (1992) found that 25 per cent of male students in Delhi reported premarital sexual experience, Goparaju (1994) on the other hand found that in Hyderabad 28 percent male students reported premarital sexual experience. The permissive sexual behavior and attitude is however not backed up by the adequate knowledge base even among, male college teachers (Verma et al, 1995) and also students (Verma et al., 1977).

The Indian evidence suggests that the prevalence of extramarital relationship is possibly less common than premarital sexual relations. A few studies conducted to assess the extent of extra-marital sexual relations in Indian families, reveal that it ranges from 1-2 percent to 9 percent among males and only about 3-4 percent among females (Nag, 1996). In a study by Narayana (1996) a significant proportion of currently married men (15 percent) admitted that they had sexual contact with women before marriage. The percentage, however, came down dramatically when only 4 percent of the men from the same sample reported that they had sex with women other than their wives after marriage.

In another study the reasons for having extra-marital relations have been observed (ICRW, 1997). The reasons men have extra-marital relations are: they are used to premarital relationships and so continue them; they are rich and can pay for extramarital sex; their wives are pregnant, hence not available or attractive for sex; and there are women available to entertain them in exchange for money. The reasons given for women having extramarital affairs, on the other hand, are they are impoverished and need money; or they are not sexually satisfied by or happy with their husbands. (p. 6).

Apart from the number of sexual partners accurate information is also needed on the type of sexual partners for biases. There is hardly any reliable estimate on this issue in India. More recent small scale but in-depth qualitative studies seem to suggest that sexual activity among college student's centers around visits to sex-workers (Bhende, 1993, 1993; ICRW, 1997). It is also reported that boys have detailed knowledge of the range of payment rates for prostitutes (ICRW, 1997). The findings regarding the condom use are however inconsistent. Very often boys reported using condoms because they feared AIDS, but not during their first few sexual experiences with sex workers.

In another quantitative and methodologically rigorous study among college youth in Mumbai, it has been reported that most sexually active college students do not use condoms and a substantial number of them have sex with commercial sex workers (Rangaiyan, 1996). From the program point of view it would be essential to understand the determinants of the potentially risky sexual behavior among males. In one analysis it has been shown that exposure to erotic materials, a liberal attitude towards sex combined with poor knowledge and perceived peer norms regarding sexual behavior are some of the most important predictors of risky sexual behavior among male students (Rangaiyan and Verma, 1997).

Continued studies would be needed to assess the knowledge, attitudinal and belief base of the community regarding various sexual practices in which the NGO's are working. These studies would also provide useful information on the

formal and informal channel's, which could be suitably utilized for program implementation.

Psycho-social and behavioral aspects of sexual health

Males, like females too undergo physiological changes. With the initiation of menarche, a girl is informed though reluctantly by mothers about menstruation. However, among males these goes overlooked as symptoms are not drastic, and literature in this regard is limited - whether boys are apprised of physiological changes and who are the informers. A study among the under-privileged group in Mumbai (Bhende, 1993) found that among the adolescent boys puberty is believed to be related to increase in height (62 per cent), growth of moustache (51 per cent), hair on chest (50 per cent), hair in genital area (26 per cent) and under arm (33 per cent). Films and television were media channels through, which boys were enlightened about reproduction. Streets often become libraries for knowledge of sex and sometimes they even become a laboratory.

Middle-aged men experience hormonal changes, especially a decrease in testosterone (Davidson et al. 1983). It may take a longer time to achieve erections, or they may experience sporadic impotence and it may produce so much anxiety that men begin to reduce sexual behavior (Ehrhardt and Wasserheit, 1991). This may cause men to avoid using condom as it may be seen as an impediment. Nocturnal emission is a subject, which causes a great deal of anxiety among young men and number of researches indicate the myths attached to the same and masturbation. (Bashayak.and Thapa, 1985; Bhende, 1993; Wasta, 1993). Although problems related to reproduction and sexual health are more, among women than men, there are some problems, which male's face and these problems have an effect on male's quality of life, and also have repercussions on women's health. STDs for example lead to infertility and cervical cancer. Urological disorders affect men and women. Problems like sexual dysfunction have deep psychological effects. Understanding the perception of men on sexual and reproductive health and how gender roles attributed to women and men affect their sexual and reproductive health becomes essential. It is necessary to examine the socio-cultural and demographic factors which influence intentions to practice certain sexual behavior, because it is behavioral and social factors, which are generally more modifiable than biological (Pandian et al, 1996).

Not many, community based studies are available on the prevalence of RTIs among men and their health seeking behavior. The Uttar Pradesh study by Narayana (1996) reported that of the total men interviewed, 13 percent had at least one perceived symptom of reproductive tract infectious. The study reported that the proportion of men who reported symptoms was close to the proportion of men who had sexual contacts with women before marriage. It is very likely

that a large number of those who had sexual contact also reported symptoms of sexually transmitted diseases. Difficulty while urinating, pain with urination, very frequent urination and swelling of testis or groins were the major symptoms reported. Nearly two-thirds of those who had reproductive tract infection symptoms consulted any one treatment and remaining one third did not consult any one.

Another study on the men's perception of illnesses of the Nether area, found that men in rural Gujarat use a relatively coherent explanatory model to describe the domain "illness of the nether area", and more significantly, this perceived domains is not synonymous with the biomedical domain of "sexually transmitted diseases" (SARATHI, 1996). The domain of the "illnesses of the nether area was a logical construct based on defining illnesses by where are they located in a particular region of the body rather than defining them according to the mode of transmission. As a result these illnesses with multiple causes as well as illnesses which are distinctly not caused by sexual contacts. Researchers of this study noted that acknowledging variation in causality of these illness will help in designing effective interventions to reduce its transmission as well as morbidity and mortality from these diseases (p. 29).

Researches on the sexual health of men will need to discuss local terminology of these illnesses, perceived severity, symptoms, perceived causes, consequences, treatment seeking and prevention. These data may prove useful in implementing effective interventions because "understanding community perceptions of disease will enable program designers to ensure that interventions make sense within the community's understanding, of illnesses (SARATHI, 1996, p. 30).

Concluding Remarks

Biomedical studies have made attempts to study the incidence of reproductive disorders. Several reports in the available literature have suggested a positive decline in human semen quality during the last 60 years. Testicular cancer is found as the most important malignancy among young men and incidence of the same has increased. Males do have problems, such as hypospadias, i.e., malformation of external genitalia and incidence of breast cancer. It has been noted that men with urethritis develop symptoms, though they ignore the symptoms and continue sexual activity before seeking medical attention. There is evidence from men attending infertility clinics suggesting that environmental estrogens have the capacity to induce adverse minor and major reproductive defects in man. Studies have also shown that as men age, the absolute level of testosterone decreases, which is accompanied by a correlated decrease in sexual activity. (Davidson, et al., 1983). In the present paper we have focused on the behavioral and psycho-social issues.

The reproductive health approach will remain ineffective unless it incorporates male's point of view even on those issues, which are intimately related to women. The reproductive Health program will have to accept the ground reality that men in a patriarchal system have a strong hold over women's reproductive health issues. This obviously is not to perpetuate the existing 'masculine mystique' but to correct the value system in such a way that it promotes greater participation and responsibility on the part of men. NG0s working in the community will need to understand the knowledge and attitudinal base of men in order to design more effective and specific intervention programs.

Notes:

1. Reader and Head. Dept. of Extra Mural Studies, IIPS, Mumbai 400 088.

2. 'Adolescent' is yet another sub-population whose reproductive health needs have received little attention due to overemphasis on the adult women in the program, and researches (Jejeebboy, 1996).

3. Until 1972-73, more than two-thirds of the total acceptance of sterilization was that of vasectomy.

4. It has been also argued that son preference is often strong enough to induce many men to put aside their economic misgivings and encourage their wives to go in for repeated pregnancies (Sehgal, 1993).

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