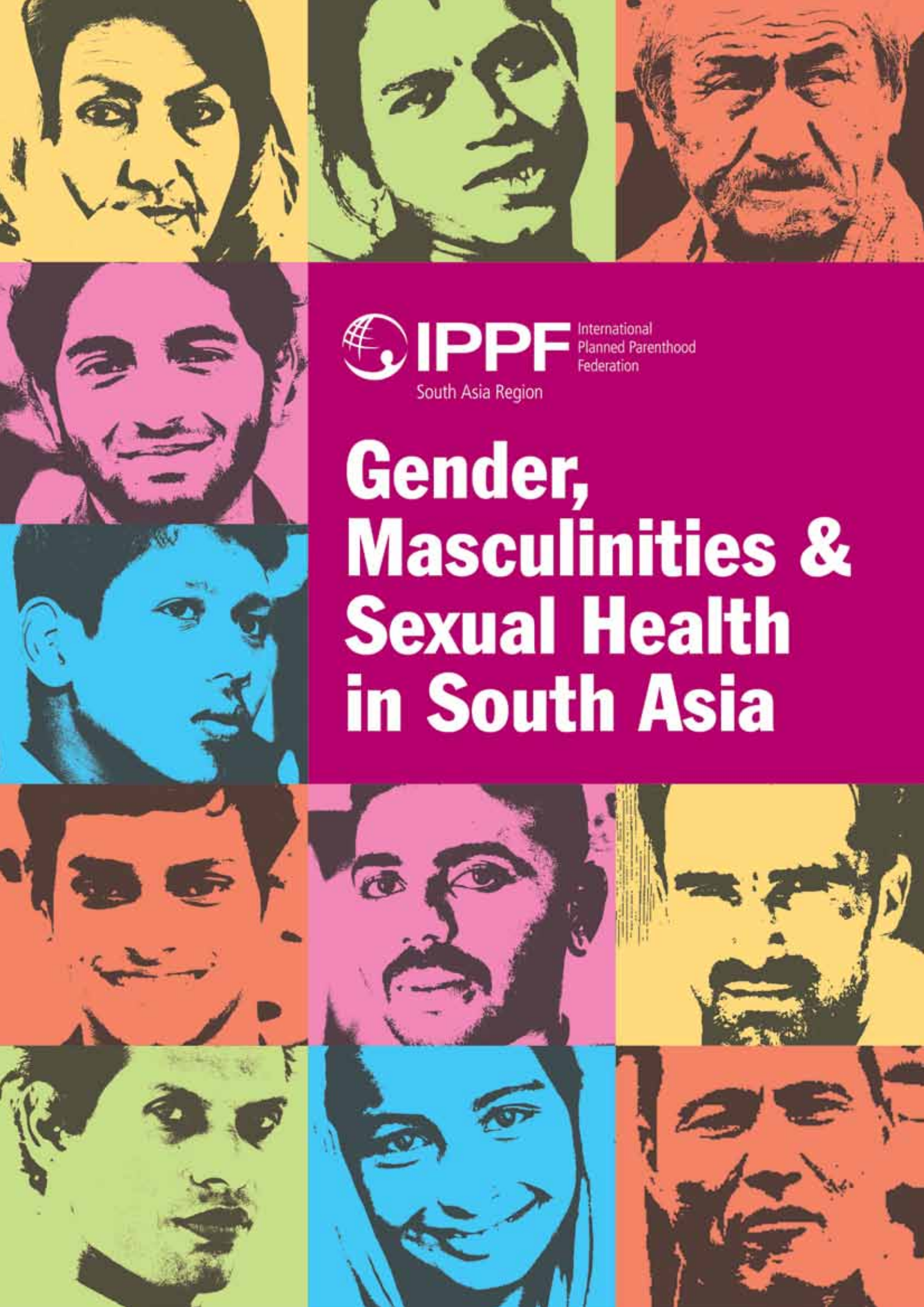

IPPF International Planned Parenthood Federation

South Asia Region

Gender, Masculinities & Sexual Health in South Asia

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International Planned Parenthood Federation
South Asia Regional Office
New Delhi

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The International Planned Parenthood Federation (IPPF) is a global service provider and a leading advocate of sexual and reproductive health and rights for all. We are a worldwide movement of national organisations working with and for communities and individuals.

IPPF works towards a world where women, men and young people everywhere have control over their own bodies, and therefore their destinies. A world where they are free to choose parenthood or not; free to decide how many children they will have and when; free to pursue healthy sexual lives without fear of unwanted pregnancies and sexually transmitted infections, including HIV. A world where gender or sexuality are no longer a source of inequality or stigma. We will not retreat from doing everything we can to safeguard these important choices and rights for current and future.

The IPPF South Asia Regional Office (SARO) covers Afghanistan, Bangaldesh, Bhutan, India, Islamic Republic of Iran, Maldives, Nepal, Pakistan and Sri Lanka through its Member Associations in these countries.

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FOREWORD

Good health is an objective that is socially determined, and gender relations form a crucial aspect of good sexual health. This study on gender, masculinity and SRH in South Asia sets out to examine 'gender' in its proper sense as a relationship between men and women, and the impact of cultures of masculinity upon sexual health of both men and women. The study suggests that cultures of masculinity impact upon the health of both men and women and that SRH programmes must explicitly address this aspect. Cultures of masculinity also have a direct relationship to sexuality and there are different ways in which this impacts upon the sexual rights of women-an aspect that the study also explores.

Masculinity affects men's health seeking behaviour in different ways. This might include the refusal to seek medical help (because it might be seen as a sign of weakness), and attitudes that militates against condom use and vasectomy. Women's health may be affected through attitudes relating to parenting, marriage, violence against women, contraception, and control of sexuality. Hence, this research approached the topic of sexual health and masculinity with the implicit assumption that masculinity is a significant factor affecting the health of both men and women in general, and that it has serious consequences for women's sexual health in particular. The study focused on men's attitude towards gender and gender roles, attitude towards women, perceptions regarding masculinity and men's communication with family members. The study used quantitative questionnaires including Gender Equity Measurement (GEM) scale as well as focus group discussions to find out men's views on gender roles and behaviours.

The findings confirm that men in the study locations, who display more gender equitable norms, are significantly more likely to self-report a range of positive behaviours and attitudes. This provides further evidence that interventions seeking to improve SRH of men and women should explicitly focus on working with men to address issues of gender (in) equity.

A number of recommendations flow from this study which has programmatic, policy and research implications.

- SRH programmes and services should include a stronger component on addressing inequitable gender norms. This should include specific interventions targeting males, highlighting the need for men to address their own health needs and their responsibilities towards the health of others.

- Programmes working on inter-partner violence should specifically target men and provide them with clear roles in prevention and to speak out against such violence.

- The importance of developing frameworks for understanding the conditions under which men's attitudes to gender equality and sexual and reproductive health show the greatest openness.

- The importance of training health workers who are active in the area of SRH to better understand masculine behaviours and anxiety, as well as in methods of collecting such information in order to incorporate it into all SRH programmes.

- The importance of integrated programmes needed to change social norms around masculinity that undermine men's and women's health. Hence, the importance of addressing beliefs that grows out of the relationship between cultures of masculinity and, say, contraception. Given the significance of the relationship between contraception, gender equality and SRH, the belief that the availability of contraceptives among women may lead to 'promiscuity' must be addressed directly.

- More research is needed to understand women's perspectives on attempts to work with men on their inequitable attitudes and behaviours and to understand policy makers' priorities and political feasibility of scaling-up a stronger focus on work with men and boys.

A number of individuals have made key contributions at various stages of this study. We are especially grateful to Ishita Ghosh, Freelance Consultant, Tim Shand of Sonke Gender Justice Network, Abhijit Das of Centre for Health & Social Justice and Sanjay Srivastava of Institute of Economic Growth for their valuable contributions and to Jameel Zamir of IPPF South Asia Region Office who led this initiative.

We would like to specially acknowledge the primary support of male and female respondents and health service providers in the study locations of India, Bangladesh, Nepal and Pakistan for their voluntary contribution.

We would also like to express our sincere thanks and appreciation to staff members of FPAB, FPAI, FPAN and FPAP for conducting this study in their respective countries.

It is our sincere hope that the findings and recommendations of this study will be widely used by different organisations particularly those working with boys and men for gender equality and SRHR in South Asia and beyond.

Anjali Sen
Regional Director
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SUMMARY OF FINDINGS

Background

Globally it is being recognised that addressing gender inequities in health, promoting SRH and preventing HIV & AIDS, unsafe abortion and gender-based violence at all levels in society is not possible without efforts to directly engage men and boys as partners in these processes (Connell 2003; Greene 2006; Townsend 2009). This necessity was clearly reflected at the 1994 International Conference on Population and Development (ICPD) Programme of Action, the 1995 Beijing Platform of Action, the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and 48th session of the Commission on the Status of Women (CSW). This perspective also finds play in the South Asian context as a variety of organisations progressively incorporate an understanding of cultures of masculinities into their public health programmes.

More recently, work seeking to engage with males on SRH issues has been regarded as central not only with a view to improving the health of women and children, but also in the hope of improving men's own health outcomes. This reflects a widening acknowledgement of men's specific health needs and growing evidence base highlighting the ways in which lack of health-seeking behaviour among men (often due to social and cultural norms shaping their attitudes) has direct health implications for the wellbeing of their partners and families (Amaro 1995; Campbell 1995; Cohen 2000).

Due to these developments there has been a proliferation of research and interventions, seeking to engage men and boys in challenging cultural and social norms, particularly in relation to gender inequalities, and promoting better health outcomes for themselves, other men, women and children (WHO 2007). Many of these interventions have been successful in improving the health of women and children, and also in addressing men's own specific sexual health needs (WHO 2007). Despite the growing interest in this area, many such interventions lack rigorous evaluation data to assess whether their work contributed specifically to gender-equitable behaviours and attitudes among men (Pulerwitz 2008).

IPPF's work on men's sexual and reproductive health and rights and men as partners in South Asia Region

IPPF has been undertaking pioneering work on engaging men and boys in gender equality, addressing their own sexual and reproductive health needs, and working with them as partners in supporting and promoting the needs and rights of other men, women and children. This includes males of all sexual orientations, including those who have sex with other men (homosexual, bisexual and transgender) and regardless of HIV status. In South Asia region, work on men and boys plays an essential role in achieving the organisational five strategic priorities:

Adolescents: Working to better address the specific health needs and rights of young men and boys, and foster more gender equitable roles and behaviours among this group.

Access: Involving men to address the gender imbalances and improve both men's and women's access to appropriate information and clinical services.

Abortion: Working to enable men to support a woman's right to choose, and to access safe abortion services.

HIV & AIDS: Involving men and boys in the provision of testing, treatment and care and in successfully preventing mother-to-child transmission and increasing condom use.

Advocacy: Working with men and boys as agents of change in advocating for the promotion of sexual and reproductive health rights of women, children and other men.

This work has been further supported and accelerated by IPPF's "Three Change Goals for 2012-2015: Unite Deliver and Perform".

Other activities undertaken by IPPF SARO include:

- Projects by Member Associations on a range of issues, including information, services and advocacy, and with a range of target groups including young men, married men, religious leaders, men who have sex with men, men who inject drugs, male sex workers and men living with HIV.

- Developing and disseminating a range of IPPF publications, including *Men's participation in SRH and rights: training manual, Men-streaming gender in sexual and reproductive and HIV: a toolkit for policy development and advocacy* and *The truth about men, boys and sex: a gender-transformative guide.*

- Conducted number of regional workshops and consultative meetings on men, masculinity and sexual and reproductive health during last five years. This brought together representatives from Member Associations as well as key partner organisations such as MenEngage Alliance, Save the Children, FHI360 and Men's Resource International, to discuss engaging men across a range of sexual and reproductive health issues.

- Research and analysis by our Member Associations to identify local sexual and reproductive health needs among men and women, and to develop strategies on engaging men and boys for gender equality and SRHR.

- Supported Aakar's *Let's Talk Men 2.0* initiative to reveal stories of masculinities from across South Asia with the intention of creating a body of representations that can together shed more light on the making of 'men' and also provide an opportunity for a public debate on the theme.

In addition, IPPF SARO has joined the Steering Committee of MenEngage Alliance in South Asia and is actively involved in the country networks. This alliance seek to engage men and

boys in promoting gender equality, enhancing sexual and reproductive health and rights and preventing HIV & AIDS and gender based violence.

IPPF SARO and SAR Member Associations are also associated with the South Asian Network to Address Masculinities (SANAM) which is a network of NGOs (national and regional), academics and activists who believe that toxicity of masculinities needs to be challenged if we are to dream of a violence free world. This network provides a platform for all people to work together in developing a culture of resistance to gender based violence.

The purpose of the project

This project aims to develop a more comprehensive picture of the understanding of, and attitudes towards, gender equity and Sexual and Reproductive Health (SRH) among men and boys in Bangladesh (Jamalpur), India (Gwalior), Nepal (Sunsari) and Pakistan (Faisalabad). It will further strengthen IPPF Member Association's capacity to find out men's sexual and reproductive health needs and concerns in their operational area. A key element of the project is the establishment and maintenance of new partnerships with other organisations working in SRH field, and in particular in-country networks working with boys and men to address gender equality and SRHR. The project also aims to proceed from an understanding of cultures of masculinities in South Asia that is drawn from social science research on the topic. The project is both explicitly and implicitly organised around the idea that in order to formulate effective SRH and public health strategies, it is imperative to take on board the actual meaning of the term 'gender'. That is to say that gender should always be understood as a relationship between men, women, and others who do not necessarily fit this binary. Hence, in order to fully flesh out the contexts within which work on gender and men's sexual health must be situated, this study will incorporate insights on the social and cultural meanings of masculinities derived from social science research on the topic. Finally in this context, the study also incorporates different ways in which a focus on gender and men's sexual health allows for an understanding of the restrictions upon and requirements of sexual rights, including those of young people, as outlined in the publications *Exclaim! Young People's Guide to Sexual rights: an IPPF declaration and Sexual rights: an IPPF declaration.*

Study objectives

In the given context, a study was conducted to address two overarching questions: what services are needed, by whom and in what settings should these services be provided. The study assesses the status of men's knowledge and attitude towards sexual and reproductive health and related behaviour.

The specific research objectives are as follows:

- To assess men's knowledge and attitude towards gender equality and sexual and reproductive health needs of women and men
- To assess men's health seeking behaviour relating to sexual and reproductive health and their vulnerabilities
- To explore service providers' own perceptions about SRH needs and vulnerability of men

Study locations

The study was carried out in India (Gwalior), Bangladesh (Jamalpur), Nepal (Sunsari) and Pakistan (Faisalabad).

Study design

Sample design and implementation

A systematic random sampling frame which is statistically sound to draw the respondents in the Member Associations operational area was applied to meet the objectives of this study. The data sampling frame contained all households within a 1.5-2km radius of selected service delivery points run by IPPF Member Associations in India (Gwalior), Bangladesh (Jamalpur), Nepal (Sunsari) and Pakistan (Faisalabad). The study used both quantitative and qualitative methods, which included bilingual semi-structured questionnaires with married men (aged 15-54), semi-structured questionnaires with health service providers and focus group discussions with men and women of the same communities. The summary of coverage for each country was as follows:

- 1475 married men (aged 15-54) were interviewed: 383 in India, 365 in Bangladesh, 374 in Nepal and 353 in Pakistan
- 12 Focus Group Discussions (FGDs) with men using PRA techniques
- 12 Focus Group Discussions (FGDs) with women using PRA techniques
- 55 health service providers (formal and informal sector) interviewed using semi-structured questionnaire: 14 in India, 14 in Bangladesh, 11 in Nepal and 16 in Pakistan

The study also used GEM scale to find out men's views on the roles and behaviours of men and women.

Characteristics of the study population

The average age of respondents ranged between 38.4-40.7 years. The proportion of men with 12 years or more of schooling was highest in India (42.3%). Majority were casual or skilled wage workers. The proportion of unemployed men was highest in Nepal along with the highest percentage of men reporting surplus (16.3).

The mean age at marriage ranged from 22.6 years to 24.9 years. Spousal age difference ranged from 6.3 years in India to 1.6 years in Nepal. The mean number of children in Bangladesh, India and Nepal ranged from 2.21 to 2.6 while Pakistan reported slightly higher number at 3.82. The mean age of men at first birth was fairly high across the countries. There are about a couple of years of spacing before the first birth. The mean household size was largest in Pakistan (8.9) and smallest in Bangladesh (4.4). A higher proportion of respondents in Nepal, Pakistan (58.6% each) had travelled away from home in the past 12 months in comparison to India (34.2%). On an average, men in Bangladesh reported the maximum number of trips away from home in the past 12 months (12.3).

Men's knowledge, attitude and use of contraception

Knowledge of contraceptive methods

Majority reported knowledge regarding any contraceptive method with a higher proportion reporting on any temporary method. Men in India and Pakistan were slightly more familiar with female sterilisation than male sterilisation while in Bangladesh and Nepal they were almost equally knowledgeable about both. The most widely reported method was condom followed by pill. Awareness on female condoms is very low while knowledge of Intrauterine Device (IUD) was in general low with the exception of Nepal. A majority in Nepal (92.8%) and Bangladesh (80.3%) and more than two third in Pakistan knew about injectables, while recall in India was very low. Modern methods are widely known in comparison to temporary/traditional methods.

Overall, men in Nepal were more aware in comparison to their counterparts. Majority had specific knowledge on condom. The small proportion aware of female condoms also had correct information on it. Correct knowledge regarding daily use of pills was the highest in Bangladesh (93.2%) while awareness in Pakistan (43.9%) was the least. With the exception of Nepal, specific knowledge on IUD and injectables was rather low. Specific knowledge about the current methods in use was high among temporary method users while female and male sterilisation users are not adequately informed.

Use of contraceptive methods

Current use of any contraceptive method is reportedly highest in Bangladesh (78%) followed by Nepal (61.8%), while roughly 5 out of 10 men in India and Pakistan reported the same. The most frequently reported contraceptive method in India (30.5%) and Pakistan (28.9%) was the male condom while female spacing methods-oral pill and injectables emerged as the preferred choice in Bangladesh (47.1%) and Nepal (32.1%) respectively. Modern methods are more widely accepted than permanent method/natural methods and accounts for majority of the current contraceptive rate.

Compared to traditional methods, there is greater openness to modern methods of contraception.

Contraceptive use is likely to increase after the birth of first child and peak in the 30-39 years age group and then decreases in the 50+ age category. In India and Pakistan, contraceptive use is likely to increase with increased educational level. Economic status does not seem to affect contraceptive use. Level of satisfaction with contraceptives currently in use was found to be high. Condom users reported higher level of satisfaction than users of female spacing methods.

Increasing educational standards are positively correlated with contraceptive use among men.

Source of contraceptive methods

Private sector emerged as the most frequently accessed source of temporary and permanent contraceptive methods with chemists being most widely accessed source followed by FPA clinic. In the public sector, district hospital and public health centres were

the most frequented sources. Friends, relatives and spouse emerged as the primary source of information on natural methods i.e., rhythm and withdrawal.

Men's attitude towards contraception

Majority in Bangladesh and Nepal and more than half in Pakistan and India disagreed that contraceptive is solely the responsibility of women and that women who use contraception may become "promiscuous". Majority in India, Nepal, and Bangladesh agreed that effective use of male condom can prevent pregnancy. Negative perception regarding condom was evident as more than half of the men across the countries agreed that male condom reduces sexual pleasure. Lack of information on male sterilisation was evident with more than half of the men in India, Bangladesh and Pakistan and more than one third in Nepal mentioning that they have no idea whether 'vasectomy is a difficult procedure'. In addition, vasectomy is also viewed by many men as a 'loss' of masculine quality, both in terms of restricting masculine essence, as well as inability to 'perform' sexually. Given this, in many cases, objections to vasectomy come not only from men but also their spouses who perceive it as 'emasculation' and hence being married to 'lesser' men.

It is possible that low rates of vasectomy are linked to lack of information and knowledge as well as prevailing social attitudes that view it as a 'lessening of masculinity'.

Knowledge on and attitude towards emergency contraception

Top of the mind association of emergency contraceptive with the prevention of pregnancy post unsafe sex was very low. Frequently reported sources of emergency contraception were chemist, government health centre, FPA clinics, and family planning workers. Majority of the respondent correctly perceived that emergency contraceptive will be ineffective if a woman misses her period. Overall, Pakistan had the most number of men who perceived the method to be effective.

Knowledge and health seeking behaviour relating to SRH and related vulnerabilities

Awareness of HIV

Majority were aware of the ways of preventing transmission of HIV & AIDS. Comparatively, more men in India affirmed ways of reducing the chances of getting infected with HIV. Condom use and sex with one partner were the frequently mentioned HIV preventive methods. Awareness on Mother to Child Transmission (MTCT) of HIV was highest in Nepal followed by India. Awareness on availability of medicines to reduce the risk of MTCT was also very low. Prevalence of misconceptions in Pakistan is slightly higher than in other three countries. With the exception of Pakistan, majority of respondents in other countries were agreeable to boys and girls getting tested for HIV before marriage. The most frequently mentioned facilities for HIV testing were government hospital and government clinic. Awareness on antiretroviral drugs was found to be low in all the countries particularly in Bangladesh and Pakistan.

Attitudes towards HIV & AIDS are also dependent upon availability of reliable information.

Sexually Transmitted Infections

Awareness on STI is in general rather low. More men in Bangladesh and Nepal had heard about STI in comparison to India and Pakistan. Across the countries, the most frequently mentioned symptoms on which awareness was reported were ulcer/sore on private parts, genital discharge, itching in private parts and burning or pain on urination. Men in the 30-39 years age group and having completed 10 or more years of schooling were most aware of STI. Nearly half of those who reported awareness on STI also reported travel away from home in the past 12 months.

A negligible percentage of men across the countries reported any STI problems and an even smaller number sought treatment. Government doctors in India and Nepal, chemist in Bangladesh and both government and private doctors in Pakistan emerged as the preferred source of treatment for STI related symptoms. Majority agreed that a man should go for a checkup if his wife has STI. Men staying with their family are perceived to have low vulnerability to either STI or HIV as compared to those who work outside home or travel or stay away from their families. Truck drivers are perceived to be highly vulnerable and at high risk followed by single men, widowers, men who have sex with men, drug addicts and rich men.

Sexual and reproductive health issues

Range of SRH problems varied across the countries. SRH problems commonly faced by men are perceived to be sexual function/dysfunction or performance related anxieties while women specific SRH problems are prolapsed uterus, pregnancy related problems. Problems common to men and women are perceived to be symptoms such as itching in genitals, STI, whitish discharge, bloody discharge, painful urination and sexual performance related problems.

Primary SRH concerns of adolescents are perceived as puberty related problems. Key concerns of adult men in their sexually most active phase were related to performance related concerns such as impotency/infertility/erectile dysfunction and anxiety related to being able to satisfy their sexual partner, symptoms of infections etc. Problems of elderly men marking the sexually less active or inactive phase were perceived as lessened sexual desire, erectile problems and burning sensation during urination. Awareness on causality of SRH problems is very low.

Men's care seeking practice for SRH problem was found to vary with the type of problems faced. Local medical practitioners emerged as the primary health care provider for SRH problems such as impotency, infertility or boils and itching in genital regions. The traditional healer (non-medico) is specifically accessed for treatment of nocturnal emission and low sperm count. Home remedies for sexual performance related problems are popular with men because of the privacy factor. For other physiological problems including symptoms of infections, treatment by private doctors is seen as most effective though cost of treatment is a deterrent.

Public health care is seen as cost effective but not favoured due to long waiting time and non-availability/poor supply of medicines. Traditional healers or service providers like *hakim*s *or vaidya*s are preferred as the treatment is affordable and easily available. Such treatment is not perceived as very effective and men often compromise on the quality of care due to the cost factor. Quality of care was found to be rated on the basis of affordability, facilitative environment, privacy, doctor's behaviour; and easy accessibility.

While hospitals and medical doctors are accessed for a range of health problems, there is strong evidence that many poor men also seek advice from traditional healers. The latter continue to enjoy the confidence of a wide cross section of the poor, particularly with regard to sexual health issues.

Men's perceptions and attitude towards of SRH problems related to women

Men perceive women's SRH problems to be "symptoms" of reproductive tract infections, burning sensation, white discharge, menstruation related problems, pain during intercourse, and infertility. Menstrual problems are associated particularly with adolescent girls; reproductive health problems are seen as commonly experienced by both adolescent girls and adult women while; problems specifically faced by adult women were cited as those related to sexual intercourse or reduced desire for sex. Men perceive that social embarrassment and stigmatisation; lack of accessible service delivery points and; lack of confidentiality/privacy are the largest concerns for women for seeking treatment.

Women perceive that adult women have more SRH problems than adolescent or elderly women. Women also perceive the primary RH problems of adolescent girls to be menstruation related. Women use home remedies to treat white discharge or seek advice from traditional birth attendants. Men perceive that women are more vulnerable to illness as compared to men and that lack of economic support and lack of awareness of SRH symptoms also increases the vulnerability of women.

Awareness on and attitude towards pregnancy/delivery and post natal care

There is a positive attitude towards prenatal checkups which increases with education index. Awareness among men in Pakistan was comparatively lower than the other countries. A small proportion of men were reportedly involved in pregnancy related care.

Men's awareness regarding signs of complications during labour/delivery indicating the need for medical assistance was not very high. Overall, awareness was slightly higher among men in India and while men in Pakistan were least aware. Majority perceives that a woman should go for post natal check up even if she is feeling fine. Awareness on post-natal complications also varied across the countries.

Men perceive that they are involved in all the stages of their wife's pregnancy while women perceive men to be involved in care giving during middle and later part of pregnancy. Men are involved in child birth in terms of making arrangements to take women to hospitals, arranging for medicines and in few cases arranging for extra nutrition etc. Women in Nepal mentioned that all male family members share the above responsibilities. Women in Pakistan feel that men prefer normal delivery because of early post natal recovery which allows women to resume normal routine soon. Men get involved with household work/child care only in case of a complicated delivery or post natal complications. Women in general do not perceive men as caregivers of newborn. Men's role in early child care is perceived as being restricted to playing with children and for older children in terms of arranging school admission, buying clothes, books etc.

There are significant differences in the perceptions held by men and women regarding pregnancy and child-birth. While men suggest that they provide considerable support during this period, women do not share this opinion.

Knowledge and attitude towards abortion

More men in India and Nepal followed by Bangladesh have a positive attitude towards abortion in contrast to Pakistan. The proportion of men suggesting abortion or unplanned pregnancy decreased with age in Bangladesh and Pakistan while in Nepal it was reverse. There is not much differential by age in India. In Pakistan proportion of men who suggested abortion for unplanned pregnancy increased with an increase in education level. A slightly higher proportion of men from surplus economy were pro-choice concerning abortion. There is not much differentials by number of children. The proportion of men who knew about the conditions under which abortion is legal in their respective countries was higher in India than in Nepal.

Men's gender related norms and behaviour

Men's perceptions of gender role/behaviour and activities

Cultural orientations to dominant forms of male and female behaviour and roles were evident. Performing household related chores and child care is seen as the primary role of women. Majority of the men perceive that husband and wife should be jointly involved in decision making about household and other financial matters. Majority perceive that decision regarding social visits to wife's family should be taken by the wife. Regarding non-financial issues such as social visits to wife's family, more men in Nepal followed by Bangladesh are likely to perceive it to be a joint decision than men in India and Pakistan.

Family planning or decision regarding the number of children was reported by a large majority to be a joint decision. Most men reportedly decide about their own health care. The data from Nepal and India reflects a more positive attitude towards education and gender equity in comparison to Bangladesh and Pakistan. Overall, men in Nepal are most likely to have a positive attitude towards gender equity while men in Pakistan are least likely to have similar attitude.

Men's perceptions of masculinity

Men expressed that they face societal expectation of earning and being a provider. Expected cultural norms of masculine behaviour deny them the space to express fears and anxieties since such behaviour is seen as feminine. Men are apprehensive of not conforming to the dominant male role and masculine behaviour for the fear of social embarrassment. Health problems such as severe depression, addiction, mental illness and at times impotency among men are perceived by them to be linked to the pressure of having to conform to dominant forms of masculinity.

Sexual concerns of single, widowed and married men

Single unmarried men are perceived to worry about sexual performance, finding a sexual partner, masturbation and related problems. Their sexual partners are perceived to be girlfriends or any 'available' girl/woman in their neighbourhood/commercial sex workers, domestic helps

and in some cases young boys. Married men living with their family are perceived to be anxious about their sexual performance and their sexual partners are perceived to be primarily their wives and in some cases sister-in-law, domestic help and commercial sex workers. Married men living separately are perceived as being worried about their wife's extra-marital sexual relations and also their own sexual life. Single widowed men are perceived as having commercial sex workers, colleagues and domestic helps as their sexual partners.

Attitude towards women

Majority in India and Nepal had a positive attitude towards a married woman's sexuality and sexual rights closely followed by Bangladesh while the proportion of men with similar perceptions was much lower in Pakistan. Men in India are most likely to justify a wife's refusal to have sex if husband has STI (91%). Across the countries, men are least likely to justify a wife's refusal to have sex if husband has had extra marital sex. Majority of the men in Bangladesh, Nepal and India had a positive attitude towards and justified a woman's insistence on condom use under both circumstances.

Violence Against Women (VAW)

Men's attitude towards VAW

In India majority of the violence was reportedly against wives, in Bangladesh and Pakistan violence against women in general inclusive of wife, sister, mother and mother-in-law as well as non-familial women i.e., others' wives and domestic helps. Primary perpetrators of VAW in India emerged as husbands and in-laws while in Bangladesh and Pakistan it included all male family members. Men are more likely to justify wife beating in case of wife showing disrespect, wife arguing with husband, and wife being "unfaithful" than in situations where wife goes out without telling husband, neglects house or children, refuses to have sex with husband, does not cook food properly or speaks to another man. Pakistan had the highest proportion of men who reportedly do not justify wife beating in the given situations. Inter-spousal violence is evidently common across the countries but is reportedly more in Pakistan and Bangladesh where women are subjected to both physical and verbal domestic violence.

Common reasons for VAW were cited to be addiction, dowry and sexual violence, suspicions about woman's moral character, non-performance of domestic responsibilities etc. In Nepal, the men said that VAW is almost a common social practice and an accepted form of male behaviour. Common forms of VAW in public spaces was reported to be eve teasing. Ironically, women themselves are blamed for getting abused. The popular perception among men is that women who dress 'inappropriately' become the primary target of sexual harassment. VAW is perceived to take place due to lack of awareness among men and there is recognition of the fact men need to be sensitised on this issue.

Men in India mentioned that women frequently deal with VAW by normalising it and justifying the act. Popular perceptions of feminine behaviour in context of sexual harassment in turn justify VAW. Women who protest against such harassment are perceived to be of amoral character. Similar perceptions are evident in case of Pakistan where participants reported that women hardly share experiences of being sexually harassed with anyone for the fear of social stigma. Women's perceptions regarding VAW are similar to that of men. Very few

women are known to seek divorce as it would socially stigmatise them. The internalisation of masculine norms by women – where they share men's perceptions of 'proper' and 'improper' behaviour as attributed to women – is a common aspect of South Asian cultures. It is, therefore even more crucial to understand the cultures of masculinities and the ways in which they influence women's lives.

Violence Against Women takes a variety of forms. What is of particular concern is the extent to which men see it as an acceptable form of male behaviour.

Gender Equitable Men (GEM) scale

The GEM scale score shows more men in India and Pakistan support inequitable gender norms (low equity) in comparison to Bangladesh and Nepal. A fairly moderate proportion of men across the countries are likely to have a positive attitude towards the items related to sexuality and reproductive health while comparatively, a lower proportion have positive attitude towards gender equity with regards household related work and child care. Across the countries, presence of culturally dominant notions of masculinity in varying degree was evident especially in India. Men across the countries are likely to have a correct attitude regarding violence against women.

Communication with family members

Men in Bangladesh and Nepal are likely to discuss general topics with family members than with non-family members while in India and Pakistan, men are more likely to discuss such issues with their peers. While men are more likely to talk to their friends than family members (mother/father) on the outcomes of sexual relationship with wife, they are likely to discuss family planning with both family and non-family members. Both family and non-family members are likely to advice on the need to have the first child soon, except in India where most get such advice from friends. Men in India get advice on delaying the first child primarily from friends while in Nepal and Pakistan similar advice is mostly given by friends and in Bangladesh by family members other than parents. Couple communication is evident in case of sexual health related problems. Men are most likely to discuss problems such as nocturnal emission and urethral discharge with their wife followed by health providers (except in Pakistan where it is the reverse). Men are also likely to discuss non-health issues such as taking up a job mostly with their spouse.

Parenting

Men are to some extend involved in the upbringing of their children but the level of involvement varied across the countries. Men are more likely to be engaged in spending time with children for physical activity/play than child care with reference to performing domestic chores. Across the countries, men in Pakistan are least likely to be involved in the lives of their children in more than one activity. More men in India are likely to now and again talk about personal matters with their children than the other countries. More men in Bangladesh are willing to cook for their children and are likely to wash clothes for their children (31%) as compared to other three countries. Men do not perceive a substantial role in neonatal care (up to one month) and sees themselves as a provider. Men perceive a lesser role in the upbringing of a girl child as they feel that girls communicate their problems only with their mothers.

Service provider's perspective on SRH needs and vulnerability

Service providers are likely to be frequented mostly by married women followed by married men. They are likely to have more interactions with younger female clients than younger male clients across all age groups. Provision of information on SRH related issues is skewed towards the married than the unmarried. Alternately, men (married and unmarried) may not be seeking these providers for sexual reproductive health information as actively as married/unmarried women. Counselling on gender and violence emerged as low on priority. Information is mostly provided through individually to the clients.

Providers are more comfortable with married women and largely comfortable discussing sexuality related topics with married and unmarried young males. Providers are not universally aware of services/programmes providing HIV/SRH related information and service to males. Men's SRH related problems were reported by more providers in India and Pakistan than in Bangladesh and Nepal. Service providers more frequently counsel on and provide contraceptives to married men than unmarried men/boys. There are attitudinal barriers in recommending contraceptive use before first birth to newly married couples. Counselling on dual protection to young married couple is also not universally practiced. Number of providers providing contraceptive services to unmarried females was much higher than those providing to unmarried males.

Abortion/post abortion related services

Less than half the providers in India and Nepal provided abortion/post abortion related services to married young females and a smaller number to unmarried females in the past three months. Provision of abortion service was also reported by a few providers in Bangladesh and Pakistan. There was difficulty in collecting data and evidence that demonstrates the safely and quality of abortion service and post abortion care in such restrictive settings.

STI and HIV & AIDS counselling and referral services

More young married females have received STI counselling, diagnosis and referral services than young married males. Most providers offer HIV counselling to married and young male and females. Provision of HIV testing to young married men and women is low. Overall, the providers perceive married and unmarried men/boys to be more vulnerable to HIV than married and unmarried women/girls. The importance of partner notification in case of RTI/STI/HIV clients is recognised by most service providers across the countries with the exception of Nepal. There is a felt need among providers for specific training on information dissemination to men on various SRH topics. Most frequently mentioned training received by providers was on the issue of family planning and care during pregnancy.

Provider's attitude towards SRH

There were mixed perceptions regarding the effects of reproductive and sexual health counselling and services on adolescents. Service providers in Bangladesh and Pakistan are more likely to perceive that contraceptive counselling may encourage adolescents to engage in sexual behaviour. With the exception of Pakistan, service providers perceive that contraceptive counselling will reduce unwanted pregnancies.

Most providers are likely to perceive that contraceptive counselling reduces the risk element in adolescent sexual behaviour. There is mixed perceptions regarding the need for counselling adolescents. Overall providers are likely to agree that adolescents should be controlled by their parents/guardians/teachers rather than be counselled. Providers in India followed by Pakistan are most likely to agree that emotional turmoil in adolescents is related to hormonal imbalance. Providers in Pakistan are more likely to agree that counselling adolescent will be more expensive since they are the biggest segment of the population.

Safe abortion services

There are varied perceptions regarding provision of safe abortion services for unmarried adolescents. Providers in Pakistan are more likely than others to associate/perceive provision of safe abortion services with reduced contraceptive usage among adolescents. Providers in Bangladesh and Nepal are more likely to perceive that provision of safe abortion service enables adolescents to have a greater control over their body. Providers across the countries expressed positively that provision of safe abortion services for unmarried adolescents will respect the choice of adolescents to terminate unwanted pregnancies. Service providers in Pakistan are least likely to positively view the provision of safe abortion services to unmarried adolescents while service providers in Nepal are most likely to have a positive attitude towards the same.

Attitude of service providers towards HIV

Lack of knowledge and information on HIV transmission among service providers especially in Bangladesh and Pakistan is reflected in the findings of the study. With the exception of Pakistan, service providers largely perceive that government facilities should provide facilities for testing anyone for HIV and that identifying people who are HIV positive should be a high priority. Service providers in Pakistan are more likely to perceive that 'HIV positive people don't really have a right to confidentiality about their infection'. Service providers in Nepal and India are more likely to recognise the importance of correct information and education related to HIV & AIDS. Overall, providers in Pakistan are likely to have more negative attitude and gaps in knowledge on HIV than those in other countries.

CHAPTER 1
INTRODUCTION

1.1 The context

Globally it is being recognised that addressing gender inequities in health, promoting SRH and preventing HIV & AIDS, unsafe abortion and gender-based violence at all levels in society is not possible without efforts to directly engage men and boys as partners in these processes (Connell 2003; Greene 2006; Townsend 2009). This necessity was clearly reflected at the 1994 International Conference on Population and Development (ICPD) Programme of Action, the 1995 Beijing Platform of Action, the Convention on Elimination of All Forms of Discrimination Against Women (CEDAW) and 48th session of the Commission on the Status of Women (CSW). This perspective also finds play in the South Asian context as a variety of organisations progressively incorporate an understanding of cultures of masculinities into their public health programmes.

The ICPD Programme of Action encourages greater male involvement/participation particularly in the roles culturally assigned to women, in order to improve and protect sexual and reproductive well-being of both men and women. Social and behavioural research is needed to examine the ways in which men and women interact (and differ) with regard to attitudes and behaviour that have an impact on sexual and reproductive health. Any research in this area needs to use a gender perspective that includes the perceptions of both men and women.

More recently, work seeking to engage with males on SRH issues has been regarded as central not only with a view to improving the health of women and children, but also in the hope of improving men's own health outcomes. This reflects a widening acknowledgement of men's specific health needs and the growing evidence base highlighting the ways in which men's lack of health-seeking behaviour (often due to social and cultural norms shaping their attitudes) has direct health implications for the wellbeing of their partners and families (Amaro 1995; Campbell 1995; Cohen 2000).

Globally, family planning and reproductive care has traditionally been women's domain. Thus, one of the greatest challenges is to develop appropriate models for providing reproductive health services for men. A crucial issue in the development of such models will be how to motivate men to use these services.

In addition to other factors, the significance of focusing on men's health lies in the fact that it has positive consequences for women's health: when men experience good sexual health, women's sexual health is also secured.

1.2 Masculinities: Ideas and concepts

'A proper understanding of the field of power in which women have lived their lives', the historian Rosalind O'Hanlon points out, 'demands that we look at men as gendered beings too'. And that we pay careful attention to:

> … what psychic and social investments sustain their sense of themselves as men, … what … networks and commonalities bring men together on the basis of shared gender identity, and what hierarchies and exclusions set them apart.
>
> (O'Hanlon 1997:1)

O'Hanlon's observations suggest that in effect, is that an understanding of the cultures of masculinity – and a focus on men as gendered beings – is crucial to an understanding of the situation faced by women in spheres such as sexual health, domestic violence, and the family. It is also a topic, as we will see later, that is significant for an understanding of the issue of sexual rights of young people. This section outlines some of the key ways of understanding masculinity as a socially produced gender identity, in order that the discussion of the rest of the study can both refer to these ideas as well as integrate them with its key objective, viz., an understanding of various contexts of men's sexual health.

Masculinity refers to the socially produced but embodied ways of being male. That is to say, masculine identities and cultures are simultaneously social and biological and neither should be regarded as 'coming before' the other. We become men and women through norms, values and expectations of the society in which live. What is important to remember is that biology always operates in tandem with social and cultural realities, and it is this combination that produces different ways of being. This way of positing the issues avoids constituting 'biology' and 'culture' as totally unrelated realms, or biology as 'prior' to culture. It also serves to emphasise the fact that 'we become human only in human society' (Padgug 1989).

Masculine identities are expressed in a variety of ways which include manners of speech, behaviour, gestures, social interaction, a division of tasks 'proper' to men and women ('men work in offices, women do housework'), and an overall narrative that positions it as superior to its perceived antithesis, femininity. The discourse of masculinity as a dominant and 'superior' gender position is produced at a number of sites and has specific consequences for women as well as those men who may not fit into the dominant and valourised models of masculinity. These sites include: customary laws and regulations, the state and its mechanisms, the family, religious norms and sanctions, popular culture, and the media.

Gender identities are produced through an interaction between biological and social factors and neither aspect can be said to be 'prior'. Biology is not a 'check' on gender capacities, since social processes influence the making of male and female identities. There are specific sites – the family, educational institutions, etc. – where men learn to be men, and women are taught to be women.

In order to stand in a relationship of superiority to feminine identity, masculinity must be represented as possessing characteristics that are the binary opposite of (actual or imagined) feminine identity. However, this is not all. Dominant masculinity stands in a relationship not just to femininity but also to those ways of being male that are seen to deviate from the ideal. It is in this sense that masculinity possesses both external (relating to women) as well as an internal (relating to 'other' men) characteristics. Both these contexts assist in bolstering what scholars have referred to as 'hegemonic' masculine identity (Connell 2005).

The ideas of 'making' and 'producing' are crucial to the study of masculinity, for they imply the historical and social nature of gender identities. The various ways in which 'proper' masculine behaviour is reiterated – in novels, films, advertisements, and folk-advice, for example, – would be unnecessary if it was a naturally endowed characteristic. The very fact that masculinity must consistently be reinforced says something about both the constructed nature of masculine identities, as well as – ironically – their fragility. By 'fragility' is meant the idea that a great deal of masculine violence derives from perceptions of having suffered a 'slight' to male honour and 'dignity': masculinity is very easily offended. Following from this, we might also say that masculinity is enacted rather than expressed. When it is said that something is expressed, it subscribes to the idea that it 'already exists', and gender identities in particular do not already exist. There is an entire task of building and rebuilding, consolidation, representation, and enforcement; in other words we must think of gender identities as works in progress. Now, if gender identities are indeed socially and historically constituted, then it is logical to imagine the possibility of effecting change in a desired direction. For, if masculine identities vary across time and space – appear in different forms at different times and are different across societies – therein lies the possibility of formulating appropriate policy measures to influence the contexts within which gender inequalities persist.

There is an additional aspect that is important to consider. This concerns the frequent attempts – both within academic and policy discussions – to discover culturally 'authentic' gender identities. It is important, however, to avoid the trap of 'extreme difference', whereby we seek to posit an absolute difference between 'western' and non-western concepts and identities. The long history of interaction between different cultures suggests that though the specificities of history and culture are important, we should be mindful that contemporary gender identities also develop in zones of interaction that are characterised by ideas drawn from diverse sources about what it is to be a man or a woman, including the processes we now refer to as 'globalisation'. Hence, as one anthropologist has pointed out, 'Rather than trying to rescue an image of a purely indigenous sexuality, distinct and untainted by "outside" Western influence, it is more useful to ask what kinds of interactions, connections and conflicts emerge in the … porous zones' (Pigg 2005:54). In the context of this study, we should also consider that contemporary masculine identities do not only draw upon local sources and histories but also, increasingly, from a transnational pool of ideas and processes. We must remember that cultures are always in flux and have a hybrid character (that is, made up of a number of different cultures). It is this aspect that, as we will see later, might explain different types of male behaviour in the different countries of South Asia.

Cultures are always in a state of flux. Hence, we must avoid the supposition that human beings have fixed ideas about their welfare. This has implications for the kinds of sexual health programmes we might choose to implement. It is important to take into account cultural aspects, but just as important to remember that these also change over time.

1.3 Gender norms, men and reproductive health

The importance of addressing the gender inequities underlying poor reproductive health outcomes is now widely recognised. Men's health seeking behaviour is often affected by their socialisation into expected gender behaviour which in many cultures encourages inequitable gender norms affecting the way men and their partners seek reproductive health care. Research exploring the relationship between masculinity and public health has documented that hegemonic masculinity is not only a major obstacle to women's improved health care but also inhibits men's proactive use of available health care systems (Meursing and Sibindi 1995; Courtenay 2000; Foreman 1999). There is also increasing evidence of negative effects of men's unmet reproductive health needs and risk behavioural patterns on the well being of women and children.

Cultural constructs of masculinity encourages men to be involved in risky behaviour and discourages men from using health care services especially sexual and reproductive health. Health care utilisation and positive health beliefs/behaviour is rejected by men are also socially constructed as forms of idealised femininity (Courtenay 1999). Lack of 'male space' in women oriented reproductive service delivery also affects men's sexual and reproductive health seeking behaviour. This often puts their partners at risk more so as gender dynamics prevents women from negotiating condom use. Research has shown that married women's greatest risk factor for STIs is the sexual behaviour of their husbands and that men are much more likely to transmit HIV to women through repeated acts of unprotected sexual intercourse than vice versa.

In South Asia, popular notions of masculinity are often characterised by male sexual dominance, unequal gender attitudes and behaviour, frequent use of violence towards women. This coupled with lack of sexual knowledge has negative consequences on reproductive health of both men and women. (Pelto and Verma 1999; Fikree and Durocher 2005). Unequal gender attitudes give men the dominant role in decision-making on women's sexuality, fertility, birth spacing, safe motherhood and other reproductive health issues.

Violence against women is another outcome of inequitable gender norms. Studies from Asia show that violence is a normative behaviour and intrinsic to the construction of masculinity (Verma 2005). Men's perception of masculinity also shapes attitude towards household roles and parenting. Research suggests that men identify less involvement with domestic roles as a part of their understanding of masculinity contributes much less time than mothers do in direct child care.

Addressing gender norms related to sexual and reproductive health is thus intrinsic to promoting gender equality, enhancing sexual and reproductive health and rights and preventing HIV & AIDS and gender based violence. The present study bases itself on these premises.

Cultures of masculinity play an important role in influencing health outcomes for both men and women.

1.4 Study objectives

In the above context, research was undertaken to assess the status of men's knowledge and attitude towards sexual and reproductive health and related behaviour. The study was intended towards facilitating the development of a plan of action to ensure that knowledge and understanding gained from the research is put into practice by MAs, and other organisations working in the SRH field.

The specific research objectives are as follows:

- To assess men's knowledge and attitude towards gender equality and sexual and reproductive health needs of women and men.
- To assess men's health seeking behaviour relating to sexual and reproductive health and their vulnerabilities.
- To explore service providers' own perceptions about SRH needs and vulnerability of men.

1.5 Study locations

The study was carried out in four countries namely Bangladesh, Pakistan, Nepal and India. The specific study location were Gwalior in India, Jamalpur in Bangladesh, Sunsari in Nepal and Faisalabad in Pakistan.

1.6 Study design

Sample design and implementation

The study used both quantitative and qualitative methods, which included bilingual semi-structured questionnaires with married men (aged 15-54), semi-structured questionnaires with health service providers and focus group discussions with men and women belonging from the same communities.

The data sampling frame contained all households within a 1.5-2km radius of selected service delivery points run by IPPF Member Associations in India (Gwalior), Bangladesh (Jamalpur), Nepal (Sunsari) and Pakistan (Faisalabad). Systematic random sampling was then used to select 1600 married men in the age group (aged 15-54), who were contacted directly. A 10% drop-out rate was expected, and in order to adjust for it 10% more than the original target sample size of respondents were selected for interview (i.e. 400, rather than 360 respondents).

The summary of coverage for each country was as follows:

- 1475 married men (aged 15-54) were interviewed: 383 in India, 365 in Bangladesh, 374 in Nepal and 353 in Pakistan
- 12 Focus Group Discussions (FGDs) with men using PRA techniques

- 12 Focus Group Discussions (FGDs) with women using PRA techniques

- 55 health service providers (formal and informal sector) were interviewed using semi-structured questionnaire: 14 in India, 14 in Bangladesh, 11 in Nepal and 16 in Pakistan

The men's questionnaire addressed characteristics of the study population, and their knowledge, attitudes and behaviours on a range of topics related to SRH and gender equity including a specific set of questions based on the GEM scale.

The health service provider's questionnaire covered background information of service provider, extent of interaction with boys and men, type of health services including counselling provided to male and female clients, potential barriers to reach boys and men and their knowledge and attitude towards sexual and reproductive health.

Data sets were entered into customised software and then transferred into SPSS for data analysis. In order to ensure the quality of data collection and entry process, field guidelines and in-depth training were provided to all field investigators and coordinators. In addition, double checking was randomly undertaken on 10-12% of the data. The data collection was carried out between June 2008 and August 2008.

To ensure quality implementation of this research project, SARO provided technical support at all the stages of this study specifically in the development of study instrument, field testing, data management and analysis and development of research report.

1.7 Characteristics of the study population

This section presents the demographic characteristic of the respondents covered by the study in order to create a context of understanding the study indicators.

Age: The age distribution of the respondents show a lower proportion in the younger (15-29) and older age groups (50+) with the majority being in the 30-49 age group. The average age ranged between 38.4-40.7 years.

Education: Overall, the respondents in India reportedly had completed more years of education than the rest of the countries with an average of 11.3 years of schooling as compared to 8.8 in Bangladesh, 8.5 in Pakistan and 8.3 in Nepal. The distribution of educational level shows that the proportion of men who attained higher education (12 years or more) is highest in India (42.3%) followed by Bangladesh (29.6%). In Nepal and Pakistan, around one fourth had completed 10-11 years of schooling. Majority of the respondents across the countries had attained at least primary education.

Occupation: Majority of the respondents across the countries are casual or skilled wage workers. More than one fourth of the men in India and Bangladesh are regular service workers. Proportion of unemployed men was highest in Nepal. The men were asked to assess their households' financial situation in the last 30 days in terms of severe deficit,

deficit, break even and surplus. Incidentally, Nepal had the highest percentage of men reporting surplus (16.3%), and break even (62%) even though it has the highest proportion of respondents who were unemployed at the time of the study. This may be explained by the fact that more than one third of men in Nepal reported that their wives were currently employed for cash. Nepal is closely followed by Bangladesh where 10.4% reported their economic status to be surplus. In this case, one fourth of the men reported that their wives were currently employed for cash.

Marital status: Majority of the men had married once and had one wife. The mean age at marriage ranged from 22.6 years to 24.9 years. Spousal age difference ranged from 6.3 years in India to 1.6 years in Nepal. Overall, the trend is towards arranged marriage with majority in India (96.9%) followed by Pakistan (95.2%) and Bangladesh (89.9) reporting arranged marriage while the gap narrows in Nepal with one third reporting love marriage.

Fertility: The mean number of children in Bangladesh, India and Nepal ranged from 2.21 to 2.6 while the mean number of children reported in Pakistan was slightly higher at 3.82. The mean age of men at first birth did not vary and was relatively high across the countries ranging from 27.49 in Bangladesh to 25.16 in India. Nearly a couple of years of spacing before the first birth was reported.

Household size: Mean household size was found to be largest in Pakistan (8.9) followed by Nepal (6.3), India (5.4) and Bangladesh (4.4).

Migration status: The respondents were asked whether they were involved in any work that required them to stay away from the house overnight or for a few days together and the number of separate occasions during which they had to travel away from home in the past 12 months. The study revealed that a higher proportion of respondents in Nepal and Pakistan (58.6% each) followed by Bangladesh (52.4%) had travelled away from home in the past 12 months in comparison to India (34.2%). On an average, men in Bangladesh reported the maximum number of trips away from home in the past 12 months (12.3) while men in Pakistan reported nearly half the number of trips, followed by Nepal (4) and India (3.7).

CHAPTER 2

MEN'S KNOWLEDGE, ATTITUDE AND USE OF CONTRACEPTION

Understanding men's role in adoption of family planning methods is crucial to addressing the ways to improve their involvement in reproductive health needs of couples. This chapter focuses on men's knowledge regarding contraceptive methods, use and level of satisfaction, and sources of contraceptive methods. It also looks at men's attitude towards contraception, knowledge and attitude towards emergency contraception.

2.1 Knowledge of contraceptive methods

The men were asked about the various ways in which a couple can delay/avoid pregnancy. The respondents were first allowed to respond spontaneously and then for each method not mentioned, the interviewers described the method and then probed for a response. *Table 2.1.1* reports percentage of men reporting awareness on permanent and temporary/ modern methods as well as emergency contraceptives.

Knowledge about any method

A vast majority reported having knowledge regarding any contraceptive method. Among those who reported having knowledge of any one contraceptive method, a higher proportion reported having knowledge on any temporary method than any permanent method. Men in India and Pakistan were found to be slightly more familiar with female sterilisation than male sterilisation while in Bangladesh and Nepal men were equally knowledgeable about both.

The most widely reported method was condom (ranging from 99.2% in Bangladesh and Nepal to 86.7% in Pakistan) followed by pill (ranging from 99.7% in Bangladesh to 70% in Pakistan and India). Knowledge of IUD was in general low (in the range of 55.1% to 47.7%) with the exception of Nepal (72.2%). A majority in Nepal (92.8%) and Bangladesh (80.3%) and more than two third in Pakistan were aware about injectables, while recall of this method in India was very low. Not much awareness on female condoms were reported.

While modern methods are widely known, there is less awareness on traditional methods like rhythm and withdrawal. Around half of the men in Bangladesh and Nepal know about the natural methods (rhythm and withdrawal) while men in India and Pakistan were less informed. Overall, men in Nepal were more aware about various methods in comparison to their counterparts in other countries (See *Table 2.1.1*). This is a significant point that informs us that cultures of masculinity even within an apparently similar cultural and social context can vary due to external influences. In this scenario we might speculate that NGO activities in Nepal has been more successful by generating awareness among men on the different kinds of contraceptive methods as well as their responsibilities as sexual partners as compared

to other countries of South Asia. Therefore, as suggested earlier, cultures of masculinity are always under construction. So, while we consider the significance of long standing social and cultural practices and behaviours upon contemporary masculine identities, we should also not rule out the importance of contemporary process in introducing new patterns of behaviour. This is certainly one way in which we should think about gender identities as identities-in-the-making. This is also an important way in which we might regard sexual rights as a context of thinking about masculinities. For, an increase in awareness of male responsibility in contraceptive practice is also an achievement of the rights of women to safe sexual health.

Table 2.1.1: Knowledge of contraceptive methods

Percentage of men who know any contraceptive method by specific method	India (N=383)	Bangladesh (N=365)	Nepal (N=374)	Pakistan (N=353)
Knowledge of any method	97.4	100	99.2	91.2
Knowledge of any permanent method	80.7	91.0	93.3	74.8
Female sterilisation	73.4	91.0	90.4	72.0
Male sterilisation	68.7	89.9	89.0	64.9
Knowledge of any modern temporary methods	94.0	100	98.1	87.8
Pill	70.0	99.7	87.7	70.0
IUD	55.1	47.7	72.2	53.5
Injectables	28.5	80.3	92.8	68.8
Male condom	88.3	99.2	92.2	86.7
Female condom	31.3	17.3	42.8	3.7
Knowledge of any natural method	29.0	67.7	69.3	45.3
Rhythm	24.3	54.8	51.6	24.1
Withdrawal	19.8	51.0	58.8	41.1

Specific knowledge about methods among those who have knowledge

Those who had knowledge on permanent and/or modern contraceptive methods were asked about specific knowledge on those methods to assess whether they had just heard about the method or had correct information on it. Specifically, they were asked whether female sterilisation can be reversed and whether male sterilisation affects sexual performance; number of sexual acts for which one condom can be used (both male and female), daily use of pills to avoid pregnancy; correct placement of IUD; frequency of injectables contraceptives; knowledge about fertile period; and correct method of withdrawal.

Majority had specific knowledge on condom use while a vast majority of the respondents across the countries correctly mentioning that one condom can be used only for a single act of sexual intercourse. The small proportion of men who were aware of female condoms also has correct information on one time use of female condoms (ranging from 75% in India to 50.6% in Nepal). Correct knowledge regarding daily use of pills was the highest in Bangladesh (93.1%) followed by Nepal (72.6%) and India (72.4%) while awareness in Pakistan (43.9%) was much less. With the exception of Nepal, specific knowledge on IUD and injectables was rather low.

Table 2.1.2 shows that though a fairly high proportion of men had reported knowledge on permanent methods, a smaller proportion among them had specific knowledge on either male or female sterilisation. The small proportion who had reported awareness on withdrawal

also reported correct specific knowledge on the method while specific knowledge on fertile period (middle of the cycle) was very low.

Table 2.1.2: Specific knowledge about contraceptive methods

Percentage of current users having specific knowledge	India (N=373)	Bangladesh (N=365)	Nepal (N=371)	Pakistan (N=322)
Knowledge about reversal of female sterilisation	28.8	30.4	55.6	7.9
Male sterilisation's does not affect sexual performance	49.8	18.0	30.3	6.1
Daily intake of oral pill	72.4	93.1	72.6	34.8
Placement of IUD (uterus)	54.5	40.2	68.1	43.9
Frequency of injection				
Monthly	16.5	5.1	5.8	3.7
Every three months	-	48.5	85.6	36.2
Male condom use for one sexual act	99.1	96.7	90.7	88.9
Female condom use for one sexual act	75.0	66.7	50.6	69.2
Knowledge about fertile period	28.0	31.5	8.8	3.5
Percentage of men who mentioned correct answer on withdrawal method (before climax)	82.9	80.1	75.0	91.0

2.2 Use of contraceptive methods

This section assesses the current level and rate of contraceptive use.

Current use

The proportion of men who reported current use of any contraceptive method by them/their spouses was the highest in Bangladesh (78.9%) followed by Nepal (61.8%), while roughly 5 out of 10 men in India and Pakistan reported to be currently using contraceptives. *Table 2.2.1* shows that there is differential preference of contraceptive methods across the study countries. While male condom is the most frequently reported contraceptive method in India (30.5%) and Pakistan (28.9%), female spacing methods oral pill and injectables appear to be the most preferred choice in Bangladesh (47.1%) and Nepal (32.1%) respectively. Use of modern methods seems to be more widely accepted than permanent methods or natural methods and accounts for majority of the current contraceptive rate. (See *Table 2.2.1*)

Table 2.2.1: Current use of contraceptive methods

	India (N=383)	Bangladesh (N=365)	Nepal (N=374)	Pakistan (N=353)
Current use of contraception	48.3	78.9	61.8	51.0
Female sterilisation	8.4	2.7	5.9	10.2
Male sterilisation	1.3	-	3.2	-
Pill	6.5	47.1	10.2	1.4
IUD	0.8	1.1	2.9	2.0
Injectables	-	4.7	32.1	3.4
Male condom	30.5	19.7	3.7	28.9
Female condom	-	0.3	0.5	0.6
Implant	-	0.3	-	0.3
Natural Methods				
Rhythm	0.3	1.9	0.8	0.3
Withdrawal	0.5	1.1	0.8	4.0

The data shows that use of any contraceptive method increases after the birth of the first child and peaks in the 30-39 years age group and continues to be high in the 40-49 age group and then decreases among the 50+ age category. In India and Pakistan, contraceptive use seems to increase with increased educational level while there is no such marked difference in the use of contraceptive method by educational level in the other two countries. In Bangladesh and Nepal, contraceptive use is lowest among the unemployed, in Pakistan among casual wage workers while in India there is not much difference in contraceptive use across occupational status. Economic status of the family does not seem to have a significant relation to contraceptive use.

Level of specific knowledge among current users

Table 2.2.2 presents the proportion of current users who have specific knowledge about the method they are using. As the table shows, vast majority of temporary methods users like condom, IUD and oral pill and traditional method user (withdrawal) have specific knowledge about the method they are using while female and male sterilisation users are not very well informed about the method in use.

Table 2.2.2: Level of specific knowledge among current users

Percentage of current users having specific knowledge on method/s Method used	India (N=146)	Bangladesh (N=262)	Nepal (N=179)	Pakistan (N=138)
Female sterilisation	40.6	20.0	50.0	13.9
Male sterilisation	20.0	0.0	25.0	-
Pill	71.4	97.7	87.9	60.0
IUD	100	100	80.0	85.7
Injectables	0.0	70.6	94.9	91.7
Male condom	100	97.2	92.3	99.0
Female condom	0.0	0.0	100	0.0
Rhythm method	0.0	42.9	0.0	0.0
Withdrawal	100	100	100	85.7

Level of satisfaction with methods currently used

The respondents were asked to rank the contraceptive methods they are currently using on a five point scale of very satisfied, satisfied, neutral, unsatisfied and very unsatisfied. Overall the level of satisfaction was moderately high with majority either reporting that they are 'satisfied' (66.3% in Bangladesh to 43.3% in Pakistan) or 'very satisfied' (52.2% in Pakistan to 13% in Nepal) with the method they are currently using. Pakistan and India where majority are condom users reported higher level of satisfaction than Bangladesh and Nepal where predominantly female spacing methods are used. The methods which were mostly frequently reported to be unsatisfactory were IUD (India and Nepal), Injectables (Bangladesh), condoms (Nepal) and traditional methods (Nepal).

2.3 Source of contraceptive methods

Private sector emerged as the most frequently accessed source of temporary and permanent contraceptive methods with chemists being reported as the most widely accessed source followed by FPA clinic. In the public sector, district hospital and public health centres were the most frequently mentioned sources.

As evident from the data, the source/s of contraceptive methods varied according to

method use. Among temporary methods, oral pills and male condoms are primarily procured from chemist. A smaller proportion also mentioned district hospital and public health centres. The exception to this is Pakistan, where oral pills and condoms were reportedly procured from FPA. For injectables, district hospitals followed by FPA in Bangladesh and FPA in Pakistan were the most frequently mentioned sources while public health centres in Bangladesh is the primary source for implants.

For permanent method (male and female sterilisation), district hospital followed by FPA clinic were frequently mentioned sources in India, district and other private hospitals in Bangladesh while in Nepal district hospitals and FPA clinic are the primary sources. As with other contraceptive methods, FPA is the primary service provider for male permanent method in Pakistan. Friends, relatives and spouse emerged as the primary source of information on natural methods i.e., rhythm and withdrawal across the countries.

2.4 Men's attitude towards contraception

Men's attitude is central to the decision making process and adoption of contraception for spacing or limiting family size. The study assessed men's attitude towards contraceptive on the basis of their response to 6 statements, two regarding contraceptive use in general, two regarding condom, and two regarding male sterilisation/vasectomy. The respondents were asked whether they agreed or disagreed with the statements.

Majority of men in Bangladesh and Nepal (86.3% and 79.4%) and more than half in Pakistan and India disagreed that contraceptive is a women's business and a man need not worry about it. Majority also disagreed with the fact that women who use contraception may become "promiscuous" (88.2% in Nepal to 66.8% in India). Majority in India (90.3%), Nepal (87.7%) and Bangladesh (81.4%) agreed to the statement that male condom if used effectively can prevent pregnancy while a much lower proportion of men in Pakistan (49.3%) held a similar view. Needless to say, an informed understanding of sexual and reproductive health issues is crucial to the achievement of sexual rights as outlined, for example, in *Sexual rights: an IPPF declaration*.

Negative perception regarding condom was evident as more than half of the men across the countries agreed to the statement that male condom reduces sexual pleasure. There is a marked lack of information on male sterilisation as more than half of the men in India, Bangladesh and Pakistan and more than one third in Nepal responded that they did not know whether 'vasectomy is a difficult procedure'. *Table 2.4.1* shows that overall, Nepal had the highest proportion of men with positive attitude and correct information on the concerned issues. We could speculate that Nepal displays different responses as compared to other countries due to the more effective work on gender related issues by NGOs in that country. This should also tell us that men's attitudes can be changed.

Table 2.4.1: Men's attitude about contraception

Percentage of men who disagree with the statements on contraception	India (N=383)	Bangladesh (N=365)	Nepal (N=374)	Pakistan (N=353)
Contraception is women's business and a man should not have to worry about it				
Agree	35.0	9.9	15.5	24.1
Disagree	58.7	86.3	79.4	64.6
Don't know	6.3	3.8	5.1	11.3
Women who use contraception may become "promiscuous"				
Agree	24.0	14.5	7.8	12.5
Disagree	66.8	77.3	88.2	72.5
Don't know	9.1	8.2	4.0	15.0
Male condom if used effectively can prevent pregnancy				
Agree	90.3	81.4	87.7	49.3
Disagree	5.2	15.3	6.1	31.4
Don't know	4.4	3.3	6.1	19.3
Condom reduces sexual pleasure				
Agree	42.6	50.7	46.0	34.6
Disagree	46.5	35.9	34.2	38.5
Don't know	11.0	13.4	19.8	26.9
Male sterilisation has no impact on sexual desire				
Agree	29.0	19.7	43.6	19.8
Disagree	25.1	20.8	18.7	29.7
Don't know	46.0	59.5	37.7	50.4
Vasectomy is a very difficult procedure				
Agree	12.0	9.0	16.0	13.3
Disagree	37.3	23.3	47.6	29.7
Don't know	50.7	67.7	36.4	56.9

2.5 Knowledge on and attitude towards emergency contraception

The men were asked whether a woman can do anything to avoid becoming pregnant if she had sex without protection. The data shows that top of the mind association of emergency contraceptive with prevention of pregnancy post unsafe sex was very low. About one fourth in India and a negligible percentage in the other countries mentioned emergency contraceptive as a method to prevent pregnancy while 'visit to hospital or chemist' was a more frequently reported option.

The men were then specifically asked whether they had heard about emergency contraceptives. Over two fifths in India, one fifth in Nepal and Pakistan and about one tenth in Bangladesh mentioned that they had heard about the method. Those who had not heard where prompted about the method and a negligible percentage reported that they knew about the method.

The frequently reported perceived sources of emergency contraception were chemist, government health centre, FPA clinics, and family planning workers. Majority of the men correctly perceived that emergency contraceptive will not work when a woman misses her period. Overall, Pakistan had the most number of men who reported (42.7%) that they perceived the method to be effective.

Table 2.5.1: Knowledge of attitude towards emergency contraception

Knowledge on methods to prevent pregnancy by women after having unsafe sex	India (N=383)	Bangladesh (N=365)	Nepal (N=374)	Pakistan (N=353)
There is nothing she can do	11.2	14.5	5.1	9.6
She can go to the hospital or clinic	17.5	20.5	47.8	11.6
She can go to the chemist	9.9	1.4	13.5	6.2
She can go to a Dai/TBA	4.7	0.5	0.3	2.0
She can take help from a quack	1.3	0.3	-	2.0
She can use some traditional remedies	1.6	-	0.3	2.0
She must wait to see if she will become pregnant	3.9	2.2	0.8	3.1
She can use emergency contraception	26.9	1.9	1.9	12.5
Other	1.3	1.9	1.4	2.8
Don't know	42.8	58.1	31.9	52.7
Heard about emergency contraception (Spontaneous/prompted)	61.8	11.1	31.5	26.1
Knowledge on sources of pill*				
Family planning workers who come to my house	26.7	42.5	23.2	3.4
Government health centre	49.0	12.5	45.5	11.2
Chemist	46.6	37.5	25.3	70.8
FPA clinics	34.5	27.5	30.3	39.3
FPA workers who come to my house	13.6	5.0	1.0	2.2
Percentage of men who correctly perceived that the emergency contraceptive will not work if women misses her period*	22.7	1.5	20.9	42.7

*calculated only those respondents who reported awareness of pills before and after the probe

Differentials by age do not show much difference in knowledge of emergency contraceptives. In India and Nepal, the proportion of men reporting knowledge on emergency contraceptives slightly increases with increase in level of education. In India, reporting of knowledge was highest among regular service workers and self employed while differentials by occupations was not much in other countries.

CHAPTER 3

MEN'S KNOWLEDGE AND HEALTH SEEKING BEHAVIOUR RELATING TO SEXUAL AND REPRODUCTIVE HEALTH AND THEIR VULNERABILITIES

Awareness on safer sex, STIs and HIV & AIDS including counselling and services are essential to ensure proactive health seeking behaviour promoting healthy reproductive life of not only married men but also their partners. This chapter presents men's knowledge on and attitude towards HIV & AIDS and STI, sexual health seeking behaviour, knowledge of pregnancy related care and knowledge and attitude towards abortion with a focus on behaviour and practices that address the reproductive health related vulnerabilities faced by men and the married couple.

3.1 HIV & AIDS

Awareness of HIV

Men's awareness regarding HIV was assessed on the basis of whether they had ever heard of HIV & AIDS, knowledge on routes of prevention and about some misconceptions on transmission of HIV & AIDS.

A large majority of men across the countries reported to have heard of HIV & AIDS. Among them, a fairly large proportion was aware of the ways of preventing transmission of HIV & AIDS. For instance, about four fifth in India and a little over two third in the other three countries were aware of the fact that 'people reduce their chances of HIV & AIDS by using condom for every sexual act' while majority agreed to the fact that 'people can reduce their chances of HIV infection by having just one uninfected partner who has no other partners'.

Misconceptions

The proportion of men having misconceptions regarding transmission routes of HIV was quite low. *Table 3.1.1* shows that majority disagreed that people get infected with HIV from mosquitoes, by sharing food with an infected person, or by hugging someone who is HIV positive. While majority in Nepal (84.9%) and India (80.1%) perceive that a healthy looking person can be infected with HIV, this perception is not as strong in Bangladesh (58.6%) and Pakistan (46.8%). Overall, the prevalence of misconceptions in Pakistan is slightly higher in comparison to the other three countries.

Table 3.1.1: Awareness and perception about HIV & AIDS

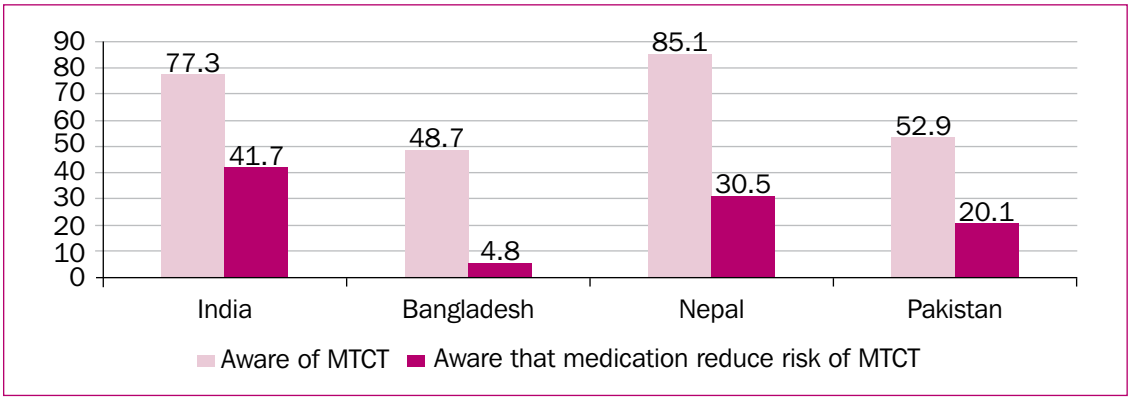
Particulars	India (N=383)	Bangladesh (N=365)	Nepal (N=374)	Pakistan (N=353)
Percentage of men who have heard of HIV/AIDS	93.2	94.0	93.6	87.8
Knowledge on ways of preventing HIV transmission among those who have heard of HIV/AIDS				
Percentage of men who perceive that people reduce their chances of HIV infection having just one uninfected sex partner	85.4	65.9	89.4	83.2
Percentage of men who perceive that people reduce their chances of HIV by using a condom every time they have sex	81.8	66.5	68.3	67.4
Misconceptions about HIV & AIDS**				
Percentage of men who perceive that people get HIV from mosquito bites	10.4	12.8	20.9	26.1
Percentage of men who perceive that people get HIV by sharing food with a person who has HIV	6.4	9.6	13.1	25.8
Percentage of men who perceive that people can get HIV by hugging someone who has HIV	6.2	4.7	6.9	27.1
Percentage of men who perceive that a healthy looking person can have HIV/AIDS	80.1	58.6	84.9	46.8

** calculated for those respondents who had heard about HIV/AIDS

Mother to child transmission

The study explored men's awareness regarding Mother to Child Transmission (MTCT) of HIV and the use of antiretroviral drugs to reduce the transmission of HIV from mother to child. While a large proportion of men in Nepal (85.1%) reported awareness on mother to child transmission of HIV followed by India (77.3%) a comparatively lower level of awareness was evident among men in Pakistan (52.9%) and Bangladesh (48.7%). Among those who knew about MTCT, specific awareness regarding the availability of medicines to reduce the risk of HIV transmission from mother to child was very low.

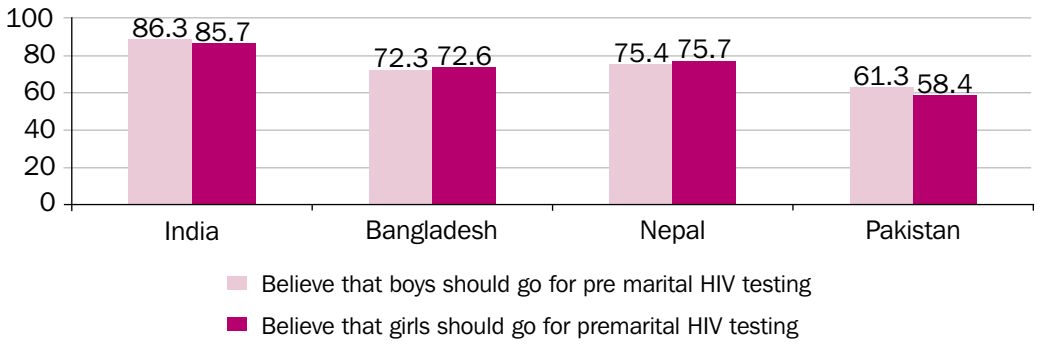
Figure 3.1.1: Awareness on mother to child transmission of HIV



Attitude towards premarital HIV testing

The men were asked about their opinion regarding premarital HIV testing for young boys and girls. A majority in India (more than four fifths), Bangladesh (approximately 72%) and Nepal (approximately 75%) expressed that a boy and a girl should be tested for HIV before marriage. The proportion of men with similar attitude was comparatively lower in Pakistan.

Figure 3.1.2: Perceptions regarding premarital HIV testing



Awareness on antiretroviral drugs and HIV testing facilities

Awareness on antiretroviral drugs was found to be low in all the countries particularly in Bangladesh and Pakistan with a small percentage of men having ever heard of antiretroviral drugs. Among those who had heard of antiretroviral drugs, more than four fifths in India and more than two thirds in Nepal reported that they knew of the place where people can avail of HIV testing facilities. In comparison, this knowledge was also rather low among men in Bangladesh and Pakistan. The most frequently mentioned facilities for HIV testing were government hospital and government clinic. A small proportion also mentioned about the private medical sector.

Table 3.1.2: Awareness on antiretroviral drugs and source of HIV testing

Particulars	India (N=383)	Bangladesh (N=365)	Nepal (N=374)	Pakistan (N=353)
Percentage of men who have heard about anti retro viral drugs	24.9	5.8	28.3	14.2
Percentage of men who are aware of source of HIV testing	80.1	46.1	67.4	38.4
Source of place				
Public medical sector				
Government hospital	81.2	39.7	64.9	34.2
Government clinic	89.9	57.1	64.9	36.1
Government mobile clinic	2.8	0.3	3.4	0.0
VCT clinic	3.4	0.6	0.6	0.6
STI clinic	3.9	1.2	0.9	0.0
Other public medical sector	0.3	0.3	2.0	0.6
NGO or trust hospital/clinic	2.8	5.8	1.4	6.1
Private medical sector				
Private hospital/clinic/private doctor	30.8	15.7	12.6	13.2
VCT clinic	2.0	0.9	0.6	0.6
STI clinic	2.2	0.0	1.4	0.0

3.2 Sexually Transmitted Infections

This section looks at men's awareness on STI and its symptoms, their experience of such symptoms and related treatment seeking behaviour.

Awareness

Unlike HIV & AIDS, awareness on STI is rather low. More men in Bangladesh (69%) and Nepal (63.1%) had heard about STI in comparison to India (56.7%) and Pakistan (39.4%). Those who had heard about STI were asked about their knowledge on specific symptoms of STI. Across the countries, the most frequently mentioned symptoms on which awareness was reported were ulcer/sore on private parts, genital discharge, itching in private parts and burning or pain during urination. See *Table 3.2.1*.

Table 3.2.1: Awareness of STIs and its symptoms

% aware of STIs and its symptoms	India (N=383)	Bangladesh (N=365)	Nepal (N=374)	Pakistan (N=353)
Percentage of men who have heard about STIs	56.7	69.0	63.1	39.4
Percentage of men who know about the symptoms of STI				
Ulcer/sore on private parts	65.0	82.9	42.5	32.8
Genital discharge	56.5	39.3	30.0	40.1
Itching in private parts	61.2	34.1	39.9	40.1
Lower abdominal tenderness/pain	9.3	9.1	8.6	20.4
Warts of growths on private parts	14.0	1.2	62.2	18.2
Burning or pain on urination	58.9	26.2	9.0	58.4
Other	2.3	2.0	3.4	8.8
Asymptomatic	2.8	-	0.4	0.7
Do not know any symptoms	6.1	3.2	4.7	12.4

In India, more than half were aware of ulcer/sore on private parts, genital discharge and itching in private parts while awareness of other symptoms were low. In Bangladesh, majority (82.9%) reported ulcer/sore on private parts as symptom of STI while a comparatively smaller proportion of men mentioned about other symptoms. In Nepal maximum awareness was regarding growth of warts in private parts (62.2%). Awareness on STI symptoms in Pakistan in general was low with the most frequently mentioned symptom being burning or pain on urination (58.4%). See *Table 3.2.1*.

Differentials in awareness of STI by background characteristics show that awareness of STI is highest among men in the 30-39 years and thereafter it declines. Education has an impact on awareness as most men who were aware had also completed 10 or more years of schooling. Casual wage workers were a little less informed than regular service workers and the self employed. Most of the men who reported awareness belonged to households with deficit situation or breakeven economy.

Nearly half of the men who reported awareness on STI also reported to have travelled away from home in the past 12 months. It is well documented that jobs that require seasonal migration or other travel (such as trucking) often are held by men. These jobs remove men from their home environment and spend less time with their spouses and families, infrequent opportunities for spousal sexual relations, and increased opportunities for sex outside of marriage or with commercial sex workers thereby an increased vulnerability to STI. (Kootikuppala 1999)

Health seeking behaviour

To understand the pattern of SRH problems faced by men and the related health seeking

behaviour, the respondents were asked whether they had experienced any SRH problems and the action taken thereafter.

The men were asked whether they had problems such as abnormal discharge from the penis and/or sore or ulcer on or near penis in the past 12 months. The data shows that a negligible percentage of men across the countries reported any of the above. (See *Table 3.2.2*) Among the small proportion of men who reported any of the above mentioned problems, a smaller number took action and sought treatment. Government doctor in India (66.7%) and Nepal (61.2%), chemist in Bangladesh (37.5%), *vaidyas*/*hakims*/homeopath (35.7%) followed by both government and private doctor in Pakistan (28.6% each) was reported as the most preferred source of treatment.

Table 3.2.2: Prevalence of STIs and health seeking behaviour

	India (N=383)	Bangladesh (N=365)	Nepal (N=374)	Pakistan (N=353)
Percentage of men who had STI during the last 12 months	5.5	0.8	8.6	2.0
Percentage of men who had abnormal discharge from their penis during the last 12 months	4.2	0.8	7.0	2.0
Percentage of men who had sore or ulcer on/ near penis during the last 12 months	4.2	3.0	6.7	2.3
Percentage of men who ever had any one of the above problems	8.4	3.8	12.8	4.2
Percentage of men who sought advice or treatment among those who had any of the above three problems	34.4	50.0	50.0	86.7
Source of treatment				
Government doctor	66.7	0.0	61.2	28.6
Nurse/paramedic	22.2	0.0	10.2	0.0
Other public sector health worker	0.0	0.0	10.2	7.1
FPA doctor/nurse	3.7	0.0	20.4	7.1
NGO worker	3.7	12.5	0.0	0.0
Private doctor	14.8	12.5	28.6	28.6
Private nurse	0.0	12.5	0.0	0.0
Chemist	0.0	37.5	2.0	14.3
STI clinic	3.7	0.0	0.0	0.0
Vaidyas/*hakims*/homeopath	0.0	12.5	0.0	35.7
Traditional healer	3.7	0.0	0.0	14.3
Others	7.4	12.5	0.0	7.1
Percentage of men who think a man should go for a checkup if his wife has STI	78.1	98.4	86.6	72.8

Majority of the respondents however believe that a man should go for a checkup if his wife has STI. Most of these men belong to the 30-39 years age group and are self-employed or regular service workers. In Pakistan and Bangladesh the proportion of men willing to go for check up was the highest among men who travelled 7-12 times away from home in the past 12 months while in India and Bangladesh, differentials by travel is not large.

Perception of vulnerability to STI and HIV

Most FGD participants perceive HIV to be a fatal illness. As per the group discussions, men staying with their family are perceived to have low vulnerability to either STI or HIV as

compared to those who work outside the home or travel or stay away from their family for work. The common perception is that men who stay far from their families have sex with other women or even men and are highly vulnerable to STI and HIV. Across the FGDs, truck drivers were reported to be a group with higher vulnerability as they are always travelling. The primary transmission route for men who stay away from home was frequently mentioned as *'bajar ki mahilayen'* (commercial sex workers). Other vulnerable or high risk groups were perceived to be single men, widowers, men who have sex with men, addicts and rich men.

3.3 Sexual and reproductive health issues

SRH problems faced by men

The men were asked about sexual and reproductive health problems that they frequently face. The data shows that the range of problems reported by men varied across the countries. In India, more men reported about SRH problems than sexual function related problems. Frequently reported SRH symptoms were: frequent urination/incontinence (64.7%), burning or pain while urinating (44%), loss of semen/nocturnal emission (30.9%), loss of semen before and after urination (27.3%) etc. In contrast, in Bangladesh the most frequently experienced problems were related to sexual function with more than four fifths reporting about shortened duration of sexual intercourse and two fifths reporting about inability to maintain an erection. In Pakistan and Nepal, a comparatively small proportion of men reported on a mix of symptoms/infections and sexual function related problems.

Table 3.3.1: SRH problems experienced by men

Percentage of men who reported SRH problems	India (N=383)	Bangladesh (N=365)	Nepal (N=374)	Pakistan (N=353)
Symptoms/infections				
Frequent urination/incontinence	64.7	27.4	2.3	23.0
Loss of semen/nocturnal emissions	30.9	41.9	25.6	30.4
Loss of semen before and after urination	27.3	19.2	3.9	21.5
Burning or pain when urinating	44	39.2	17.8	20.9
Pain in the testicles	10.2	11.2	2.3	14.4
Bumps or sores anywhere on the genitals	2.2	2.2	2.3	9.2
Discharge from genitals	3.3	9.9	12.4	10.1
Inflammation of one of the testicles	1.5	1.1	2.3	8.0
Open sores	1.5	0.8	0.0	10.1
Bleeding from genitals	1.8	6.0	0.8	10.7
Itching or burning	33.1	15.3	29.5	20.9
Pain during sex	14.5	4.7	15.5	12.3
Sexual function related problems				
Shortened duration of sexual intercourse	25.5	81.9	20.2	42.6
Unable to maintain an erection/impotence	9.8	40.5	3.1	19.6
Ejaculation before coitus	16.4	11.0	3.9	16.3
Sexual anxieties				
Anxieties about the penis	14.2	5.2	7.8	12.6
Worries about masturbation	20.7	6.8	3.1	30.7
Other	0.0	0.0	0.0	2.1

During focus group discussions (FGDs) with men, the study explored SRH problems faced by men, common beliefs and practices related to SRH, treatment seeking behaviour and practices, barriers to treatment seeking and perceptions of vulnerabilities related to STI

and HIV. The methodology used is as follows: the men were given a list of SRH problems experienced by both men and women. From this list the participants were asked to identify the problems as faced by men, women and by both. Thereafter, they were asked to sort out the cards into three piles – most, less common and least common problems and further into most, less and least distressing problems and finally into problems for adolescent boys, adult men and elderly men.

Analysis of the FGDs reveal that SRH problems faced by men were related to sexual function/dysfunction or performance related anxieties such as premature ejaculation, masturbation, nocturnal emission, anal sex, anxieties about the size and shape of genital organs, hydrocoele etc. 'Performance' related anxieties are a particular salient aspect of the cultures of masculinity in South Asia. In particular this is connected to the notion of normative or 'ideal' sex which the 'real' man is supposed capable of 'living up to'. That is to say, a significant aspect of masculine sexual identity is the idea that a 'real man' can both 'satisfy' his sexual partner as well as achieve sexual satisfaction for himself. Inability to provide sexual satisfaction to one's wife is frequently cited as an sign of 'inadequate' masculinity and a context where the wife might seek other liaisons and broadcast the fact of her husband's 'inadequacy'. Ideas – or, anxieties – regarding size and shape of genital organs are also manifestations of masculinities. A significant aspect of the sexual 'advice' provided by the innumerable 'traditional' healers across South Asia relates to sexual performance and how to improve it (Srivastava 2007). Vast arrays of herbal remedies are recommended to overcome putative shortcomings, whether in terms of sexual performance or biological factors such as penis size.

A significant aspect of masculine sexuality relates to notions of power, and a 'real' man is imagined to be a sexually powerful person, able to 'satisfy' his wife as well as achieve sexual satisfaction. Women who engage in extra-marital relationships are frequently subject to violence on the grounds that they have undermined their husbands' sense of masculinity.

SRH problems listed by women included were prolapsed uterus and pregnancy related problems. Common problems listed by men and women were symptoms such as itching in genitals, STI, whitish discharge, bloody discharge, painful urination and sexual performance related problems such as loss of sexual desire, painful intercourse, worries about size and shape of genital organs etc.

The FGDs revealed that frequently mentioned 'most common' S&RH problems experienced by men were those related to sexual dysfunction or performance related anxieties such as inability to maintain erection/erectile dysfunctions, premature ejaculation along with nocturnal emission, anxieties/guilt about masturbation etc. and symptoms such as burning sensation while urinating, itching in the genital areas etc.

Performance related anxieties like impotency and loss of sexual desires, anxieties about shape/size of penis, sperm deficiency along with symptoms such as boils or itching in genital region were listed as less common but most distressing problems. No doubt, such 'distress' relates to the extraordinary hold of the perceived connection between masculine identity and factors such as sexual impotence and penis size. Indeed, sexual impotence is synonymous with loss of masculinity, or at least that kind of masculinity which is held to be ideal. Hence, it is for

this reason that in South Asia, the eunuch is considered as lacking masculine essence. Least common problems were listed as symptoms such as pain during intercourse, hydrocoele, lumps in the genital areas, bloody discharge, Syphilis, TB etc as well as sexual performance related anxieties such as impotency, inability to satisfy partner, inability to ejaculate etc.

The FGD participants were further asked to divide the list of common S&RH problems in three categories: problems faced by adolescence boys, adult men and elderly men.

Masturbation, nocturnal emission (*swapna dosh*), STIs, burning sensation while urinating and anxiety about smaller size of penis are seen as puberty related problems and were listed as the primary concerns of adolescent boys. Key concerns of adult men marking the sexually most active phase were related to performance related concerns such as impotency/ infertility/erectile dysfunction and anxiety about being able to satisfy their sexual partner. Besides, sexual performance related problems, symptoms of infections such as itching in genital region or swollen testicles or boils were also listed as SRH problems of adult men. Problems of elderly men marked the sexually less active or inactive phase with problems such as lessened sexual desire, erectile problems and burning sensation during urination.

The matrix below shows the categorisation of S&RH problems at different stages of life/by various age groups as perceived by men.

Adolescent boys	**Adult men**	**Elderly men**
Growing up phase: Puberty related problem as such as masturbation, nocturnal emission. STIs, and anxiety about smaller size of penis as well as burning sensation while urinating	**Sexually active phase:** Performance related problems and concerns such as impotency/infertility/erectile dysfunction and anxiety of being able to satisfy their sexual partner. Besides, symptoms of STI such as itching in genital region or swollen testicles or boils	**Sexually inactive/less active phase:** Impotency/infertility along with the performance anxiety for not being able to satisfy their sexual partner. Symptoms such as itching in genital region or swollen testicles or boils

Beliefs related to casual factors of SRH

The men were asked about their perception regarding the causal factor of common SRH problems. An analysis of FGDs shows that the awareness on causality of SRH problems is very low. The men expressed that there are some traditional beliefs related to causal factors of SRH problems such as 'having sex after drinking alcohol results in sexual impotency and also produced weak child' or that 'excessive masturbation turns blood into water' and causes 'sexual weakness'. In Bangladesh, men cited that in popular beliefs, SRH problems are perceived as beyond the control of humans.

Apart from traditional or religious beliefs, men also mentioned other causal factors ranging from external factors such as negative influence of television and cinema or 'bad' persons, inappropriate dressing by girls/women thereby exciting men, to physiological causes such as excessive masturbation, lack of nutrition, hereditary

factors and vasectomy. It is to be noted that none of the FGDs had any discussion on high risk behaviours like unprotected sexual intercourse or lack of hygiene etc., as the causal factor of SRH problems.

The media is a significant influence on disseminating ideas about masculine norms and identities. It is important, therefore, to utilise the media – including new information technologies – to disseminate messages that counter stereotypical notions regarding manhood.

Care seeking behaviour

As it emerged from the group discussions, care seeking behaviour among men for SRH problem varies with the type of problem faced. In case of problems such as symptoms/infections they visit a doctor or healer, but for dealing with problems such as masturbation related anxiety/guilt, premature ejaculation, impotency, nocturnal emission and sexual performance related anxieties they prefer discussing with their friends. Some mentioned that problems such as premature ejaculation and sexual performance related anxieties are also discussed with one's spouse. Though, impotency or infertility or other sexual performance related anxieties were listed as distressing SRH problems, there was no mention of seeking medical advice on these problems. Participants from a group mentioned that men prefer taking recourse to religious rituals or home remedies to find a cure for the problems. This may well be due to the fact that as these 'illnesses' are considered signs of loss of masculine virility, men do not wish to advertise their condition widely and prefer to consult those – such as friends and traditional healers – who may be expected to keep confidence.

Preferred service providers

As per the group discussions, men primarily seek health care services from private health care providers but also visit traditional healers and seek home remedies. The local medical practitioners emerged as the primary health care provider for SRH problems such as impotency, infertility or boils and itching in genital regions. The traditional healer (non-medico) is specifically accessed for the treatment of nocturnal emission and low sperm count. Home remedies like eating groundnuts or consuming herbs or leaves (*jadi-buti*) mixed in drinks like milk or buttermilk are practiced to overcome sexual performance related problems and nocturnal emission.

While men access primary health care services for SRH issues, it is also clear that they seek counsel from traditional healers. Further, it is possible that they may under-report such visits in formal surveys and questionnaires.Notwithstanding this, the latter have not been the focus of attention in SRH programmes. Given that large number of men visit traditional healers and feel a greater degree of comfort with them rather than with medical doctors, it is important to seriously consider if it might be possible to incorporate traditional healers within strategies of SRH for men.

Barriers/facilitating factors in seeking services

Home remedies for sexual performance related problems is popular with men because of the perception that it can be conducted in privacy and therefore does not expose a person's illness or status and also while it may not be an effective cure, it will not have any

side effects. For other physiological problems including symptoms of infections, treatment by private doctors is seen as most effective but at the same time the cost of treatment is often a deterrent. Public health care on the other hand is seen as cost effective but is often not favoured due to two reasons: long waiting time and non-availability/poor supply of medicines. In this respect, traditional healers or service providers like *hakim*s or *vaidya*s are preferred as the cost of treatment is low and medication is affordable and easily available. However, such treatment is not perceived as very effective. Thus, due to the affordability factor, men often compromise on the quality of care.

As it emerged from the group discussions, men consider the following factors while judging the quality of care of various service providers: good facilities with low treatment cost; affordable or free medicines; doctor's behaviour towards clients; effective and speedy recovery in one visit; facilitative environment where client is assured of privacy and easy accessibility.

3.4 Men's perceptions and attitude towards SRH problems related to women

Awareness on SRH problems of women

The study assessed men's awareness on SRH problems of women. Alongside, FGDs were also conducted with women on similar issues. Viewpoints of both men and women have been presented below on the various issues on which their awareness was assessed.

Awareness of men

Men listed women's SRH problems mainly as symptoms like boils, itching and wounds in genital region, burning sensation, white discharge, irregular menstruation, excessive bleeding, pain during intercourse and impotency. Menstrual problems like irregular menstruation, excessive bleeding and pain during periods were cited by men to be the most common SRH problems of women along with other problems like itching in genital region, white discharge, lessened sexual desires and burning sensation during urination. Along with these SRH problems other general health problems like gastritis, pain in joints, anaemia, and headache are also listed as women's SRH problems. The least common SRH problems of women as listed by men were infertility, pain during intercourse, prolapsed uterus and yellow discharge (*peela paani*). Men perceive symptoms such as white discharge, yellow discharge, burning sensation during urination, itching in genital region, lower back pain and menstrual problems to be the most distressing conditions for women.

The men were further asked to list SRH problems of women as per categories of women namely, adolescents, adult women and elderly women. It emerged from the FGDs that men perceive that menstrual problems is particularly experienced by adolescent girls; RH problems like white discharge, burning sensation during urination, excessive bleeding during menstruation, lower abdominal pain during menstruation are commonly experienced by both adolescent girls and adult women. Problems specifically faced by adult women were cited as those related to sexual intercourse such as pain during intercourse or reduced desire for sex. Anaemia, headache, lower back pain, vomiting, loss of appetite, irritation were cited as problems faced by women across age groups.

They further expressed that women feel inhibited to seek remedy for the fear of social embarrassment and stigmatisation. Men pointed out that lack of medical service delivery points for providing treatment for women and expressed that accessibility and confidentiality/privacy are the two largest concerns for women seeking treatment.

Awareness of women

The study also conducted FGDs with women. The women were asked to list common health problems faced by adolescent girls, adult and elderly women. The women identified the most common problems for adolescent girls to be related to menstruation related lower abdominal cramps, irregular and painful periods or pain after periods. Women in India and Pakistan specifically mentioned problems such as burning urination, white discharge, headache, dizziness, fever etc. In India, women also mentioned that some adolescent girls have health problems such as lumps in breast and boils in genitalia.

Analysis of FGDs suggests that adult women are perceived as facing more SRH problems than adolescent or elderly women. Most of the problems reportedly faced by adult women are reproductive health related problems for example, infertility, miscarriage, fever after child birth, swelling of belly after child birth, premature delivery etc. Some women also mentioned about menstruation problems such as excessive bleeding, irregular menstruation. Symptoms like burning and painful urination, lump in breast, whitish or yellow discharge, bleeding other than periods were also listed as problems faced by adult women.

The most common problems of elderly women are perceived to be aging problems such as joint pain, weakness, headache, backache, pain in legs and watery eyes. Besides, the women mentioned that elderly women also face some reproductive health problems such as whitish discharge, boils in the genitals, burning urination etc. Some of them mentioned about loss of sexual desire as an SRH problem. A few cases of adult and elderly women having the problem of prolapsed uterus were reported in India.

Men's knowledge of women's care seeking behaviour

Men perceive that women share most of their SRH problems with their husbands. They expressed that women tend to share SRH problems primarily with husbands in order to prevent any inter spousal problems. In this context a FGD participant said that "if a woman shares such problems with anyone else then her husband may start suspecting her" *(shak kar sakata hai)*. In absence of their husbands, women reportedly share their SRH problems with their mothers and mother-in-laws.

Men feel that women often seek advice on SRH problems from other women (friends) to avoid going to hospital and that medical help is not sought until the problem becomes serious. Few women are also believed to be seeking advice from *Angan Wadi* Workers (community-based women worker under Integrated Child Development Scheme, ICDS in India). Men also reported that women use home remedies to treat white discharge or at times seek advice from traditional birth attendants in their village. Men perceive that women are not proactive about health care seeking either because they feel embarrassed to go a doctor or they have no one to accompany them to the doctor or treatment is not affordable.

Men's attitudes towards women's SRH problems

Men admit that women are more vulnerable to illness as compared to men because they are burdened with work. Across the groups men mentioned that few women feign illness to save themselves from additional work burden *('nakara karati hai'/kaam se bachne ke liye bahana karti hai).* In some cases lack of economic support from the husbands and lack of awareness of SRH symptoms also increases the vulnerability of women. Some men expressed that even if a woman is ill, her husband still demands sex and she cannot refuse him.

3.5 Awareness on and attitude towards pregnancy related care

Men's attitude towards and awareness on pregnancy related care is indicative of their involvement in prenatal, maternal and child care. In this context, the study assessed their attitude towards, prenatal care, awareness on complications during pregnancy, signs indicting labour, post natal care and complications.

Awareness on prenatal complications

A vast majority of men held positive attitude towards prenatal checkups. They agreed that women should have regular checkups during pregnancy even if she is feeling fine (93.9% to 83.8%). Most men who held this view fall in the 30-49 age group. Positive attitude towards prenatal checkups increases with education index.

To assess their awareness on and understanding regarding prenatal complications, men were asked about the signs of complications during pregnancy that signify the need for medical help. In general, 'pain in the abdomen', 'feeling weak tired', vomiting and 'swelling of hands and face' were the most frequently reported signs of prenatal complications.

Some of the frequently mentioned signs of complications in India were 'feeling weak tired' (India 58.5%) 'pain in the abdomen' (India 46.5%), swelling of hands and face (32.6%) and vaginal bleeding (32.4%). In Bangladesh men frequently mentioned, 'feeling weak tired' (57.5%), vomiting (39.7%) and severe headache/blurred vision (30%) while in Nepal men cited pain in the abdomen (47.6%) followed by feeling weak/tired (32.1%), vaginal bleeding (27.5%) and fever (27.3%). See *Table 3.5.1*

Table 3.5.1: Men's knowledge about pregnancy related care

	India (N=383)	Bangladesh (N=365)	Nepal (N=374)	Pakistan (N=353)
Percentage of men who say that women should have regular checkups during pregnancy even if she feels fine	90.1	83.8	93.9	88.1
Percentage of men who were aware about signs of complications during pregnancy that need assistance from a health care provider				
Feeling very weak/tired	58.5	57.5	32.1	18.1
Swelling of hands and face	32.6	18.1	21.9	10.5
Severe headache and blurred vision	20.6	30.1	17.6	11.0
Fever	26.6	17.8	27.3	16.7
Pain in abdomen	46.5	26.3	47.6	25.8
Vaginal bleeding	32.4	9.6	27.5	16.4
Vomiting	27.9	39.7	19.3	28.0
Loss of appetite	22.5	17.0	5.9	17.8
Baby not moving	17.2	3.0	12.0	19.5
Back pain	8.6	2.2	5.3	19.3
Other	2.3	-	1.1	2.5
Don't know	11.5	14.2	16.3	32.3
Percentage of men who accompanied spouse to prenatal visit (at least once)	70.3	69.0	54.9	58.1

Awareness among men in Pakistan was comparatively lower than the other countries with nearly one third of the men reporting that they were not aware of any signs of pre-natal complications. Among those who had awareness, vomiting (28%) and pain in abdomen (25.8%) were two most frequently mentioned signs of prenatal complications followed by baby not moving and back pain (19.5% and 19.3% respectively). As reported in *Table 3.5.1*, though men reportedly had a positive attitude towards prenatal checkups, a far less proportion of men are actually involved in pregnancy related care and accompanied their wives at least once for prenatal checkup (70.3% in India to 54.9% in Nepal).

Differentials of men who accompanied wife by age shows a large proportion of men in India and Bangladesh the 30-50+ age group reportedly accompanied their wives for prenatal check up. In contrast in Nepal and Pakistan the proportion of men is slightly high only in the 30-39 age group and proportionately lower in other age categories. Education has a positive effect on men's participation in prenatal care of women as a higher proportion of men with 10 or more years of schooling across the countries reportedly accompanied their wives for pre-natal checkups. Economic status of the family seems to have a bearing on men's involvement in wives pre-natal care only in case of Pakistan. Except for Bangladesh, differentials by employment status of wife are negligible. Husband's travel away from home does not seem to have a significant relation to men's participation in wife's prenatal checkups.

Awareness on complications during labour/delivery

As with prenatal complications, men's awareness regarding signs of complications during labour/delivery which indicate that a woman should be taken to a hospital/doctor was not very high. Overall, awareness on various labour/delivery complications was slightly higher among men in India than in other countries. As with signs of complications during pregnancy, awareness among men in Pakistan about labour/delivery complications was

comparatively lower than the other countries with two fifths reporting that they are not aware of such signs of complications.

Some of the most frequently mentioned delivery related complications were 'baby lying sideways' (India 50.9%, Bangladesh 23.3% and Nepal 26.5%) 'labour too long' (Nepal 54.0%, India 39.9.%, Bangladesh 30.7% and Pakistan 24.1%), 'fits/convulsions' (Bangladesh 50.7%, India 21.9%), 'bleeding before baby is born'(India 31.3%), placenta not coming out (Nepal 29.7%) and narrow vaginal passage (India 23%). See *Table 3.5.2*

Table 3.5.2: Awareness on complications during labour/delivery

Percentage of men aware of signs of post natal complications indicating the need for medical help	India (N=383)	Bangladesh (N=365)	Nepal (N=374)	Pakistan (N=353)
Baby lying sideways	50.9	23.3	26.5	17.0
Labour too long	39.9	30.7	54.0	24.1
Fever	24.8	23.6	17.1	13.6
Fits/Convulsions	21.9	50.7	4.8	7.1
Bleeding before baby in born	31.3	8.5	29.9	19.0
Water breaks but labour does not start within 24 hrs	39.9	12.3	10.7	7.6
Narrow vaginal passage	23.0	5.5	9.1	19.0
Placenta not coming out	10.4	6.0	29.7	10.2
Other	2.9	0.5	1.9	9.1
Don't know	15.4	15.1	21.4	41.6

Awareness on post natal complications

A large percentage of men felt that a woman should access post natal checkup facilities even if she is feeling fine. However, as seen in *Table 3.5.3*, compared to prenatal checkups, the proportion of men with positive attitude towards post natal checkups drops slightly.

As with awareness on pregnancy and delivery related complications, awareness on post natal complications also varied across the countries. For instance, 71.2% in Bangladesh reported awareness on heavy bleeding as a sign of post natal complication while this knowledge was much lower in other countries. Again, 47.3% in Nepal and 40.7% in India reported awareness on 'pain and tenderness in abdomen' as sign of post natal complications while only about one fourth in Bangladesh and less than one fifth in Pakistan were aware of the same. Some of the frequently reported signs of post natal complications were 'heavy bleeding', 'fever and chills', 'pain and tenderness in abdomen', 'bad smelling vaginal fluid', 'legs swollen', 'retained placenta', 'aches and pain/fatigue' etc.

Table 3.5.3: Knowledge of warning signs of complications following child birth

	India (N=383)	Bangladesh (N=365)	Nepal (N=374)	Pakistan (N=353)
Percentage of men who says women need to go for check up following child birth even if she is feeling fine	83.0	77.8	89.0	84.1
Percentage of men who reported knowledge of warning signs of complications following child birth				
Heavy bleeding	49.3	71.2	44.1	29.5
Fever and chills	34.2	18.6	30.5	11.9
Pain and tenderness in abdomen	40.7	26.0	47.3	17.0
Bad smelling vaginal fluid	26.1	12.1	16.5	11.9
Severe depression	10.7	8.5	3.5	13.9
Legs are swollen	31.9	12.6	14.1	10.8
Breasts are swollen	15.9	5.5	11.9	12.7
Retained placenta	11.0	15.6	34.1	8.2
Fatigue	12.8	4.1	8.6	25.2
Aches and pains	21.1	2.7	11.4	28.0
Other	1.6	1.1	2.2	0.8
Don't know	17.0	12.6	13.2	33.4

Men's participation in women and child care

The qualitative research focused on men's involvement in women's health and child care.

Men's participation in Ante Natal Care (ANC)

Men in course of FGDs expressed that it is the role of the husband to be involved in care of a pregnant women as opposed to father, father-in-law/brother-in-law. Discussions on the nature of involvement husbands have revealed that participants perceive a husband to be involved in all the stages of pregnancy. They elaborated that during early pregnancy a husband oversees that his wife is receiving medical checkups and taking adequate and appropriate food on time. Some men participate by accompanying their wife for medical checkups or vaccination and overseeing that she is follows the doctor's instructions.

In the second trimester, men are cautious about their wife's health and advice her not to do any work that involves picking up heavy things or makes sure that she takes rest. In the third trimester, men specially oversee that she is eating on time, not undertaking heavy work, not climbing stairs and taking adequate rest. The participants mentioned that some men help by doing groceries and household chores like cooking.

Women's perceptions of men's role/involvement in ANC

FGDs with women revealed that women also perceive men to express care during middle and later part of pregnancy in terms of taking care of their wives' nutrition, immunisation, health check up forbidding them from taking up heavy work etc. Women in Nepal and to some extent in India mentioned that husbands express care and concern during early pregnancy by helping with household chores. Women in Nepal also mentioned about some men provide emotional support to them during pregnancy. In contrast, Pakistani women said that most husbands generally did not provide any help during early part of pregnancy and start caring during mid pregnancy. While they themselves do not assist with the household chores, they arrange for someone to help with housework in the late pregnancy.

Men's role/involvement during child birth

Men are involved in child birth in terms of making arrangements to take women to hospitals, arranging for medicines and in few cases arranging for extra nutrition etc. Women in Nepal mentioned that apart from husbands, all male members of the family share these responsibilities. Some women in Pakistan said that men are happy in case of normal delivery because there is early post natal recovery and women can resume normal routine soon. In case of a complicated delivery and post natal complications, some men carry out housework like cooking, cleaning or arrange someone to do so, take care of children etc. Generally men do these works only when there is no help.

Most women FGD participants in India perceive that men do not participate in post natal care and that post natal care is primarily provided by other women. Women in Nepal in contrast mentioned that that most men arrange for extra diet, vaccination and regular check up of the baby and the mother.

Evidence of men's role during the processes of pregnancy, ante-natal and post-natal care suggests meager participation during these important periods in a woman's life-cycle. It is important to investigate the influence of masculine cultures in this context: what is considered 'men's business' as opposed to 'women's'?

As gathered from FGDs, most women do not perceive men as caregivers of newborn. In absence of a female family member, sometimes the father, grandfather or uncles take part in the care giving. Men's role in early childcare is perceived by women as being restricted to playing with children. This role is mostly attributed to the grandfathers as they often stay at home. In case of older children the father is primarily perceived as being responsible for arranging school admission, buying clothes, books etc. Older children are also helped with their studies or dropped and picked up from school by their fathers, grandfathers or sometimes by uncles. Some women mentioned that children are often trained in a family occupation by the older men in the family. The processes of socialisation are divided according to gendered notions of tasks and spheres 'proper' to men and women. So, it is generally accepted that the realm of domestic and the activities that take place within it belong to women. Indeed, masculinity is defined through the spaces and activities that are seen to be its 'natural' domain. Thus, as also discussed below – masculine identity is defined through its association with 'public' (as opposed to 'private') spheres. Hence, men deal with school authorities as well as provide training in work-related activities that provide an income, an aspect that is linked to ideas of the male as 'bread-winner'. It is in these ways that different genders learn 'proper' behaviour.

3.6 Knowledge and attitude towards abortion

The study focussed on men's attitude and knowledge towards abortion. Men's attitude towards abortion was assessed by taking their opinion regarding the action to be taken by a woman in case of an unwanted pregnancy. *Table 3.6.1* shows that majority in India and Nepal (more than four fifths) were of the opinion that the woman should undergo an abortion in case of unwanted pregnancy while a slightly lesser proportion of men in Bangladesh held the same opinion. In contrast, more than half of the men in Pakistan were of the opinion the woman should continue with the pregnancy.

Differential by age shows that the proportion of men who suggested abortion for unplanned pregnancy decreases with age in Bangladesh and Pakistan while in Nepal it is the reverse. There is not much differential by age in India. Differentials by level of education is noticeable only in case of Pakistan where proportion of men who supported an abortion for unplanned pregnancy increases with an increase in education level. A slightly higher proportion of men from surplus economy (upper wealth quintile) were more likely to be supportive of a women's decision to terminate a pregnancy. There is not much differentials by number of children.

Further, to assess men's knowledge regarding abortion, they were given certain situations or conditions and asked whether in their opinion a woman should be able to undergo an abortion. The situations provided were as follows: woman does not want another child; woman cannot afford another child; woman is unmarried; the pregnancy is an accident/result of contraceptive failure; the pregnancy is a result of rape; the woman's health is endangered by the pregnancy; there is a strong chance of serious defect in the baby; the foetus is female; the foetus is male and; the foetus is more than 20 weeks pregnant.

As can be seen in *Table 3.6.1*, majority of men in India agreed to the fact that abortion is acceptable in case the woman is unmarried (92.4%), pregnancy is a result of rape (93.5%) and the woman' health is endangered by the pregnancy (around 93%). A slightly lower proportion of men felt that abortion is possible in case there is a strong chance of defect in the baby (88.3%), woman does not want another child (83.8%), and woman cannot afford another child (80.9%). A lesser proportion of men felt that abortion is possible if pregnancy is a result of contraceptive failure (77.8%). The study indicates that there is no significant difference in attitudes of respondents towards abortion despite the gender of foetus. A little more than two thirds were of the opinion that a woman would not be able to have abortion if she is more than 20 week pregnant.

In case of Bangladesh, the most frequently mentioned situations where a woman should be allowed to undertake an abortion were-pregnancy is a result of rape (95.9%) and woman is unmarried (94%). In case of the first two situations i.e., woman does not want another child and woman cannot afford another child, a majority of men across India (83.8% and 80.9% respectively) Nepal (77.8% and 74.3% respectively) and Bangladesh (77.8% and 70.7% respectively) were of the opinion that abortion is possible while in Pakistan only a small proportion of men agreed with the same.

A vast majority in India (92.4%) and Bangladesh (94%) opined that abortion is possible in case the woman is unmarried while a lesser proportion of men in Nepal (79.1%) followed by Pakistan (62.6%) held the same view.

Table 3.6.1: Knowledge and attitude towards abortion

	India (N=383)	Bangladesh (N=365)	Nepal (N=374)	Pakistan (N=353)
Perceptions of men on unplanned pregnancy				
Nothing/Continue with the pregnancy	8.4	8.2	5.3	56.7
Get an abortion	86.2	71.0	81.6	22.9
Other	0.3	0.3	1.1	3.4
Don't know	5.2	20.5	12.0	17.0
The woman does not want another child				
Yes	83.8	77.8	77.8	24.4
No	12.0	21.6	12.0	65.2
Don't know	4.2	0.5	10.2	10.5
The woman cannot afford the child				
Yes	80.9	70.7	74.3	24.9
No	14.1	27.1	15.5	61.5
Don't know	5.0	2.2	10.2	13.6
The woman is unmarried				
Yes	92.4	94.0	79.1	62.6
No	5.2	5.2	7.8	23.8
Don't know	2.3	0.8	13.1	13.6
The pregnancy is an accident (result of a contraceptive failure)				
Yes	77.8	76.4	73.0	34.0
No	13.6	22.5	13.9	53.0
Don't know	8.6	1.1	13.1	13.0
The pregnancy is a result of rape				
Yes	93.5	95.9	89.0	76.2
No	3.1	3.3	2.7	10.8
Don't know	3.4	0.8	8.3	13.0
The woman's health is endangered by the pregnancy				
Yes	93.2	71.5	83.7	70.8
No	3.1	23.8	9.1	21.0
Don't know	3.7	4.7	7.2	8.2
There is a strong chance of a serious defect in the baby				
Yes	88.3	67.4	65.0	56.7
No	5.5	26.8	21.9	33.1
Don't know	6.3	5.8	13.1	10.2
The foetus is female				
Yes	7.8	15.6	14.2	14.4
No	86.9	79.2	78.3	70.5
Don't know	5.2	5.2	7.5	15.0
The foetus is male				
Yes	7.8	13.2	10.4	9.3
No	85.6	81.9	82.4	74.8
Don't know	6.5	4.9	7.2	15.9
The women is more than 20 weeks pregnant				
Yes	9.9	12.3	17.4	13.9
No	68.9	53.7	70.9	47.0
Don't know	21.1	34.0	11.8	39.1

Men in India and Nepal were asked a set of specific questions to determine their knowledge on legal tenets under which abortion is permissible in their respective countries. Specifically, they were asked whether abortion is legal in the following circumstances: the woman is unmarried; the pregnancy is an accident (result of a contraceptive failure); the pregnancy is a result of rape, the woman's health is endangered by the pregnancy, there is a strong chance of a serious defect in the baby and; the women is more than 20 weeks pregnant. *Table 3.6.2* below gives details of awareness levels of men regarding the legal issues surrounding abortions.

Table 3.6.2: Knowledge of legality of abortion in India and Nepal

Legality of abortion under following situations	India	Nepal
The woman is unmarried		
Legal	78.6	65.9
Not legal	13.1	17.0
Don't know	8.4	17.0
The pregnancy is an accident (result of a contraceptive failure)		
Legal	70.0	60.0
Not legal	16.7	19.7
Don't know	13.3	20.3
The pregnancy is a result of rape		
Legal	85.6	74.6
Not legal	6.8	11.4
Don't know	7.6	14.1
The woman's health is endangered by the pregnancy		
Legal	85.6	83.0
Not legal	6.0	7.3
Don't know	8.4	9.7
There is a strong chance of a serious defect in the baby		
Legal	84.9	61.4
Not legal	5.0	22.4
Don't know	10.2	16.2
The women is more than 20 weeks pregnant		
Legal	27.4	32.5
Not legal	49.3	48.8
Don't know	23.2	18.7

India and Nepal have both made progressive changes to their national policies and created laws which allow abortions for not only preventing injury/disability in mother or the child due to pregnancy or a pregnancy caused by rape but also for unintended pregnancies resulting due to contraceptive failure in married women. Nepal has a task shifting policy under which even health workers on peripheral centres are trained and equipped to provide abortion services and both countries have made attempts to communicate these issues to their general populace. To gauge the effectiveness of these interventions, the respondents of this survey were asked about the legal situation in their country. The overall awareness of men regarding legal allowances for abortion was more in India than in Pakistan and the difference in most cases is not significant. In Nepal only two-thirds of men knew that serious defects in the foetus can be a indication for abortion which may indicate that though both countries show a remarkably high awareness and knowledge of legal status of abortions-there is still a need to continue the IEC efforts to bring about universal clarity on these issues.

CHAPTER 4

MEN'S GENDER RELATED NORMS AND BEHAVIOUR

One of the primary study objectives has been to assess men's knowledge and attitude to gender equality and sexual and reproductive health needs of women and men. Studies show that gender inequities not only have negative impact on women and their health care but gender role expectations may also affect men and their health seeking behaviour. Proactive health seeking behaviour may go against socially constructed forms of male behaviour and thereby be rejected. In some cultures, male gender roles may encourage risk-taking and thereby discourage men from using health care services (Moynihan 1998) including reproductive health risks, such as having sex without condoms (Foreman 1999). In the South Asian context, the ability to suffer physical pain is frequently regarded as an index of masculinity, and hence it is not surprising that men's health seeking behaviour is constrained by forms of socialisation that militate against seeking medical attention when required. The ability to 'soldier on' is both valued as a masculine trait and its perceived absence decried as a sign of masculine 'deficiency'. Anecdotal evidence suggests that South Asia continues to have a greater proportion of widows than widowers. The health costs of masculinity can, literally, be fatal and, in this context, we might consider men to be a vulnerable group as well.

Gender role expectations and norms in certain cultures may restrict men from participating in the household tasks and management, partner's health care especially sexual and reproductive health and child care. Societal expectations of endorsing dominant norms of gender behaviour may encourage some men to adopt alternative measures, such as violence, to maintain authority in the family (Greig, Kimmel and Lang 2000) and control over the behaviour of their female partners. Recent study in India demonstrates that use of violent behaviour was integral to the cultural construction of a 'real man' (Verma et al. 2005). Studies from Pakistan also reiterate similar findings. (Fikree, Razzak and Durocher 2005). In general, gender based violence, including domestic violence can be regarded 'not only as a form of physical abuse, but also a process of disempowerment. ... [And as] a mechanism of social control and part of a system of social order' (Cribb and Barnett 1999:49). A significant body of analysis has tended to proceed from the perspective that domestic violence occurs as a *consequence* of social disorganisation. Further, a frequent connection was made between men's violent behaviour and their 'innate' aggressiveness (Bourke 1999; Ehrenreich 1997). However, it has increasingly been pointed out that violence towards women – including domestic violence – can be better understood as an attempt to *maintain* existing structures of gender power, rather than a breakdown in the social order. Hence, feminists increasingly suggest that 'we need to see violence as bound up with the very constitution of cultural forms' (Cribb and Barnett 1999:51).

In the above context, the study focussed on men's attitude towards gender and gender roles, attitude towards women, perceptions regarding masculinity and men's communication with family members. The study used quantitative questionnaires including Gender Equitable Men (GEM) Scale (Pulerwitz and Barker 2006) as well as focus group discussions to find out men's views on the gender roles and behaviours.

4.1 Men's perceptions of gender roles and behaviour

To assess men's perception of and attitude towards gender related norms and behaviour, a series of questions were addressed to them spanning over issues such as gender related tasks and activities, gender role in decision making process; sexual rights of wife, gender and education, gender relations etc.

Men's perceptions of gender related activities

In course of the focus group discussions, men were shown a series of faceless sketches of individuals doing a set of tasks and were asked to group them into tasks typically performed by women, men and both. The analysis reflects that men's perception of the tasks are clearly gender defined with women being seen as responsible for tasks in the private domain/household and men being seen as responsible for tasks in the public domain or outside the household.

Thus, daily household chores like cooking, house cleaning, washing and ironing clothes, buying vegetables as well as child care including feeding children, preparing them for school, playing with them, etc. were marked by men as tasks typically performed by women. In comparison, any outdoor tasks were marked as tasks meant for men. Besides, leisure activities such as reading newspapers and watching television were also marked as male activities. Among household chores, ironing clothes and accompanying women to hospitals were marked as tasks that can sometimes be undertaken by men. Tasks least likely to be performed by men were listed as engaging with children for their studies and taking care of children. In fact, cross country studies show that fathers tend to contribute about one third to one fourth of the time that mothers do in child care (Population Council 2001).

Cultural orientations to dominant forms of male behaviour and roles were evident from perceptions that men have to work outside their homes to earn a living because they have to be the provider as per social norms. As stated by one of the FGD participants, men need to do the outside work or take care of their wives and children as they felt that the 'husbands are the guardians of their wives'. Some of the men articulated that they perceive men to be stronger than women and can carry out heavy work and therefore they work outside the household.

The dominant perception that women belong to the private domain ie; the household and that performing household related chores and child care is the primary role of women was further justified by expressions such as it is 'hazardous for women to work outside home as they may be vulnerable to an unsafe environment'. Thus, work outside home is seen as unsuitable for women as women are seen as 'weak and unable to cope with the outside environment/elements, higher risk factors and physical strength'. As mentioned by a FGD participant:

"Women are less educated and therefore they should not go outside as the situation is also not very good and anything bad could happen to them if they stepped out."

The public/private distinction is crucial towards an understanding of the ways in which masculinity both gets defined and functions as a structure of power. There is, in fact, a close relationship between the so-called public and private spheres. For example, if the parliament is imagined as the realm of men and the home as that of women, then each gender comes to be established as having its 'proper' realm of operation (Pateman 1989; Fraser 1992). This, is turn, has significant consequences for the freedoms and constraints experienced by men and women.

Our everyday lives unfold upon and through specific spaces. Further, spaces have a dual identity: they are both sites upon which different social identities play out, as well as sites for the formation and consolidation of identities. So, for example, the home is commonly understood to be the domain of women, but it is also the space that defines the kinds of activities women may take part in. Similar arguments can be made for other spaces such as streets, parks, offices, bazaars, shopping malls, schools and university campuses.

It is in this context that we need to focus upon the significance of the ideas of the 'public' and the 'private' and the ways in which it influences gender identities and behaviours. It is certainly true that the idea that each gender has a separate sphere to which it 'naturally' belongs has become part of modern 'common sense'. Hence, it is commonplace to imagine certain spaces (such as streets and offices) as public and others (say, the home) as private. There is also the belief that different spaces have their own characteristics and that each gender more naturally belongs to one space or another. Hence the idea that men belong in public spaces and women in the private is predominantly accepted. Also, while on the surface 'public' and 'private' may seem like opposed concepts, they should, in fact, be thought of as complementary. That is to say, it is because one sphere (the public) is understood as that of men, the other is imagined as that of women. Further, there is the popular perception that each gender has its own space in which to function and flourish and hence there is 'balance': if men have dominance over the public sphere, women similarly dominate the private. In actual fact, however, the relationship between the public and private spheres is one of 'superior' and 'inferior', similar to that between men and women.

If we remember that the public sphere has historically been defined as that of men and the private as that of women, then it becomes easier to understand why the two operate as complements to bolster gendered power. So, if the public is presented as the domain of action, 'rationality', 'educated opinion', and a realm where important matters of social life can be discussed among the 'rightful' claimants to the public sphere—men—then the private is imagined as that sphere where men can find relief from the 'difficult' tasks of engaging and forming the public sphere. The private is represented as the 'soft' sphere where other kinds of—'feminine'—sensibilities come into play. Here, women rule as they are supposedly endowed with those qualities that are best suited to the domestic sphere: capacity for maternal care and emotional response, lack of ability for 'rational' and 'scientific' thinking and capacity for thinking about concrete matters such as the state, and abstract matters such as philosophy. The important thing to remember is that without the notion of

the private, the public would not carry the connotations of a superior realm that it does. It is in this sense that the two are complementary. This also helps us to understand the hostility that women face should they choose to place themselves in the imagined public sphere: masculine anxiety and hostility guards the public as a realm of men. What we have, in effect, are masculinised public spheres.

4.2 Masculinised public spheres and institutional discourses

The relationship between violence, public spaces and masculinity is important to understand in order grasp how gendered ideas play out across various contexts of civil society and agencies of the state. This will further allow us to see how masculinised notions of the home and the world are produced and reinforced in different social contexts. That is to say, ideas regarding gender roles and behaviours – and inequities – must be understood and analysed across a number of different social contexts. These might include the family, schooling, village associations, and the legal system. It is in this context that we might think of the idea of a 'masculinised public sphere' (Moon 2002) that is produced through both private and public discourses on gender. When we speak of the masculinisation of the public sphere, we refer to the combination of a number of discourses—such as the familial, religious, legal etc. – through which masculinity and its effects are produced.

Gender role in decision making

In many cultures, men, are the decision makers, about family planning, their wives' economic activities, use of household resources, as well as education of children. Women are marginalised from the decision making process and this has a direct bearing on their health seeking behaviour. Thus, men's attitude towards gender role in decision making is crucial in shaping the health care behaviour and general well being of the family.

Men's attitude towards gender role in decision making was assessed in reference to financial, social, and health decisions. The men were asked who among the husband or wife should have a greater say in decision making process, in case of major household purchases, daily household purchases, wife's earnings, visit to wife's relatives, family planning and seeking health care for self.

The data shows that on the whole men perceive husband and wife should be jointly involved in decision making about household and other financial matters including wife's income. *Table 4.2.1* shows that a higher proportion of men across the countries perceive both husband and wife should together decide about major household purchases (77.3% in Bangladesh to 62.6% in Pakistan). However, regarding daily household purchases, there were varied perceptions with more than half in Bangladesh and Pakistan reporting that it is a joint decision while more than half in Nepal expressed that it should be the wife's decision. In India, about two fifths of the men were of the opinion it should be decided by both while an almost equal proportion (39.4%) felt that the wife should decide. See *Table 4.2.1*.

Most men in India (85.9%), Nepal (78.6%) and Bangladesh (75.1%) perceive that husband and wife should jointly take decisions about the money earned by the wife from her work while the proportion of men with a similar view is lower in Pakistan (56.7%). In fact Pakistan had a slightly higher proportion of men in comparison to the other countries who felt

that the wife should decide about her own earnings (almost one fourth). Regarding non-financial issues such as social visits to wife's family, more men in Nepal (82.4%) followed by Bangladesh (72.3%) are likely to perceive it to be a joint decision than men in India and Pakistan (roughly 66%).

Decision regarding the number of children a couple should have, is perceived by a large majority as a decision to be jointly taken by the couple (92% in Nepal to 81% in Pakistan). Most men in India and Pakistan reported that they themselves decide about their own health care (91.4% and 83.3% respectively) while in Bangladesh this decision is either taken by self or spouse (around 49%). See *Table 4.2.1*.

Table 4.2.1: Men's attitude towards gender role in decision making

	India (N=383)	Bangladesh (N=365)	Nepal (N=374)	Pakistan (N=353)
Making major household purchases				
Husband	18.8	14.0	14.7	23.5
Wife	3.9	8.8	15.8	12.7
Both	76.2	77.3	69.3	62.6
Don't know	1.0	-	0.3	1.1
Making purchases for daily household needs				
Husband	17.0	20.0	8.3	21.8
Wife	39.4	21.1	52.7	25.8
Both	41.8	58.9	38.8	51.3
Don't know	1.8	-	0.3	1.1
Deciding what to do with the money the wife earns				
Husband	6.8	6.0	4.0	14.2
Wife	5.5	16.7	16.6	23.5
Both	85.9	75.1	78.6	56.7
Don't know	1.8	2.2	0.8	5.7
Deciding about visits to the wife's family or relatives				
Husband	15.7	17.8	4.0	19.0
Wife	17.8	9.9	13.4	14.2
Both	65.5	72.3	82.4	65.7
Don't know	1.0	-	0.3	1.1
Deciding how many children to have				
Husband	6.8	5.8	4.0	12.7
Wife	5.5	1.4	3.7	3.4
Both	85.9	91.2	92.0	81.0
Don't know	1.8	1.6	0.3	2.8
Deciding on seeking health care for self				
Self	91.4	49.6	87.2	83.3
Wife	21.4	49.3	25.6	37.7
Parent/Parent-In-Law	2.9	1.1	1.9	3.7
Brother/Sister-in-law	0.3	-	-	0.8
Other Relatives	0.3	-	-	0.8

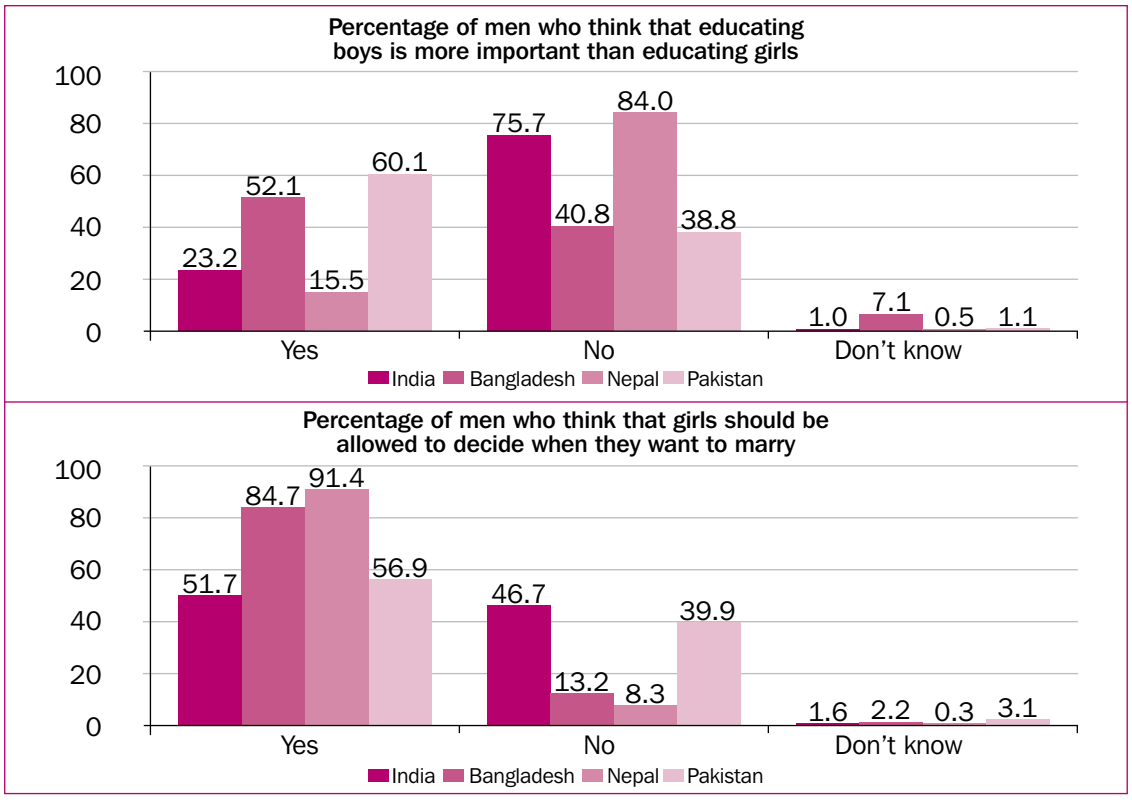
Perceptions of gender equity

Gender perceptions of men were assessed in terms of their perceptions of gender vis a vis education and gender vis a vis decision making regarding marriage. The data shows contrasting opinions across the countries. The data from Nepal and India reflects positive

attitude towards education and gender equity with 84% in Nepal and 75.7% in India disagreeing with the statement that educating boys is more important than educating girls while comparatively a much lower proportion of men in Bangladesh and Pakistan (around two fifths) had similar perceptions.

With regards to gender and marriage, a large proportion of men in Nepal (91.4%) and Bangladesh (84.7%) showed a positive attitude and agreed with the statement that girls should be allowed to decide when they want to marry while only a little more than half of the men in India and Pakistan were of the same view. Overall, men in Nepal are most likely to have a positive attitude towards gender equity while men in Pakistan are least likely to have a similar attitude. Interestingly, men in both India and Bangladesh displayed contrasting attitude towards gender equity. Men's attitudes towards gender equity, particularly as it relates to the issue of women's ability to take decisions regarding their sexual and partnering choices, are crucial to an understanding of the sexual rights of women. So, for example, as the *Sexual rights: an IPPF declaration* document points out, 'Sexuality, and the pleasure deriving from it, is a central aspect of being human, whether or not a person chooses to reproduce' (Principle 4, p. V). Further, as the document also outlines, 'the right to choose whether or not to marry, and to found and plan a family, and to decide whether or not, how and when, to have children; (Principle 9, p. VII) is also a cornerstone of sexual rights. Clearly, these rights can only be ensured if – given the significant role of male elders in the lives of both young women and men – men's attitudes towards gender equity change. We will have further occasion to observe below how the notion of sexual rights, as outlined in *Exclaim!* as well as *Sexual rights: an IPPF declaration*, form an important part of the broader context of the present study.

Figure 4.2.1: Attitude towards gender equity



4.3 Men's perceptions of masculinity

The FGD participants were asked about their perception regarding the kind of freedom men enjoy. The participants expressed that men enjoy 'privilege of mobility, freedom of decision making, freedom to have sex and ability to fight and speak/express their thoughts freely'. The FGD participants were further asked about constraints faced by men. It emerged from discussions that the primary constraint faced by men is societal expectation of having to earn even in adverse conditions. Discussions further revealed that the expected cultural norms of masculine behaviour produces behavioural constraints that restrict men from being able to share their problems with others and denies them the space to cry or express fears and anxieties since such behaviour is seen as feminine. Men are apprehensive of not conforming to dominant male role and masculine behaviour for fear of social embarrassment.

These constraints (lack of space to communicate/express fears anxieties) and the resultant predisposition to conform to culturally given norms of masculinity may result in poor health seeking behaviours. Some FGD participants pointed out that as a fall out of the pressure of having to conform to dominant forms of masculinity, many men suffer from health problems such as severe depression, addiction, mental illness and at times impotency.

Sexual concerns of single widowed and married men

The FGDs probed men's perceptions about the sexual concerns of single unmarried men, single widowed men and married men. The discussion revealed that men perceive single unmarried men to worry about their sexual performance, finding sexual partner masturbation and related problems. It is perceived that their sexual partners are their girlfriends or any 'available' girl/woman in their neighbourhood including commercial sex workers, female domestic helps and in some cases in young boys.

Married men living with their family are perceived to be anxious about their sexual performance and their sexual partners are perceived to be primarily their wives and in some cases sister-in -law, house maid and commercial sex workers. Married men living separately are perceived as being worried about their wife's extra-marital sexual relations and also their own sexual life.

As perceived by the FGD participants, married men have their wives, commercial sex workers, colleagues and girlfriends as their sexual partners. Similar perceptions were articulated by the discussants about single widowed men. Their sexual partner was perceived to be anyone available but generally commercial sex workers, colleagues and female domestic helps.

4.4 Attitude towards women

To assess men's attitude towards women, the men were asked to respond in terms of agree, partially agree and disagree to a series of statements as follows:

- In the workplace any gain by one sex necessitates a loss by the other
- When women work they are taking jobs away from men
- When women get rights they are taking rights away from men
- Right, for women mean that men lose out

- In all societies it is inevitable that one sex is dominant
- It's impossible for men and women to truly understand each other
- Men and women cannot really be friends

As seen in *Table 4.4.1*, there were mixed perceptions regarding statements on gender and work. A little more than half of the men in Nepal and India disagreed that 'any gain in workplace by one sex necessitates a loss by the other', while more men in Bangladesh and Pakistan either agreed or partially agreed with the statement. While a large percentage in Nepal had positive attitude towards women working outside the domestic sphere and disagreed with the statement that 'when women work they take jobs away from men', the score progressively drops in case of India, Pakistan and Bangladesh.

Nepal scored high on positive perceptions regarding women's rights with well over four fifths disagreeing with the statements-'when women get rights they are taking rights away from men' and; 'rights for women mean that men lose out', followed by India (over two thirds) while Bangladesh and Pakistan had comparatively lower scores.

Perceptions regarding gender equity were largely negative with men across the countries either agreeing or partially agreeing that 'in all societies it is inevitable that one sex is dominant'. The proportion of men who perceive that men and women can truly understand each other and can be friends is overall low with the exception of Nepal. Among the other three countries, men in India are more likely to disagree with the statements than Bangladesh and Pakistan.

The attitude of respondents towards women was calculated by adding up the score (1 to 3) of the above seven questions which ranged between 7 and 21 and had subsequently been grouped into three categories respectively, 7-11 (low), 12-16 (medium) and 17-21 (high). On this scale, Nepal had the largest proportion of men with high score. See *Table 4.4.1*.

Table 4.4.1: Gender perceptions

	India (N=383)	Bangladesh (N=365)	Nepal (N=374)	Pakistan (N=353)
In all societies it is inevitable that one sex is dominant				
Agree	32.4	41.1	25.9	37.7
Partially agree	32.1	21.9	26.5	37.7
Disagree	35.5	37.0	47.6	24.6
In the workplace any gain by one sex necessitates a loss by the other				
Agree	15.1	22.5	25.4	20.1
Partially agree	31.6	28.8	17.1	38.2
Disagree	53.3	48.8	57.5	41.6
When women work they are taking jobs away from men				
Agree	15.4	54.8	7.2	17.8
Partially agree	22.2	18.9	7.5	32.6
Disagree	62.4	26.3	85.3	49.6

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	India (N=383)	Bangladesh (N=365)	Nepal (N=374)	Pakistan (N=353)
When women get rights they are taking rights away from men				
Agree	14.1	56.4	5.3	17.0
Partially agree	20.6	7.7	7.0	26.6
Disagree	65.3	35.9	87.7	56.4
Rights for women mean that men lose out				
Agree	14.4	13.7	5.9	17.8
Partially agree	21.1	29.3	5.3	26.1
Disagree	64.5	57.0	88.8	56.1
Its impossible for men and women to truly understand each other				
Agree	28.7	22.2	22.7	32.3
Partially agree	20.9	31.0	14.7	26.9
Disagree	50.4	46.8	62.6	40.8
Men and women cannot really be friends				
Agree	19.6	23.8	8.0	28.3
Partially agree	19.1	23.0	9.9	28.6
Disagree	61.4	53.2	82.1	43.1
Attitude towards women				
Low	10.4	27.7	5.9	19.3
Medium	40.5	33.7	21.7	39.9
High	49.1	38.6	72.5	40.8

Attitude towards women's sexual rights

In order to understand men's perceptions about and attitude towards a wife's sexual rights, men were asked whether it is justified when a woman refuses to have sex with her husband if he has STI; has had extramarital sex and; if she is tired or experiences discomfort/pain.

Majority in India and Nepal demonstrated a positive attitude towards married woman's sexuality and sexual rights, while the proportion of men with similar attitude was a little less in Bangladesh and much lower in Pakistan. *Table 4.3.2* shows that men in India are most likely to justify a wife's refusal to have sex if husband has STI (91.9%). In contrast, in Nepal, Bangladesh and Pakistan men are most likely to justify a wife's refusal to have sex if she is tired or experiences discomfort pain than if the husband has STI or extra marital sex. Across the countries, men are least likely to justify a wife's refusal to have sex if husband has had extra marital sex.

The respondents were further asked if they justified a women's insistence on condom use if she did not want a baby and if her husband has any problem in the genital areas. As seen in *Table 4.4.2*, majority of the men in Bangladesh, Nepal and India had a positive attitude towards and justified a woman's insistence on condom use under both circumstances. Comparatively in Pakistan, a much lower proportion of men held similar views. Among them, men are most likely to justify the situation if the wife or her husband has any problem in genital areas than if the wife does not want another baby. See *Table 4.4.2*.

Table 4.4.2: Attitude towards women's sexual rights

Men's attitude towards women's sexual rights	India (N=383)	Bangladesh (N=365)	Nepal (N=374)	Pakistan (N=353)
Wife's refusal to have sex				
Percentage of men who justify wife's refusal to have sex if husband has STI	91.9	78.9	89.3	79.9
Percentage of men who justify wife's refusal to have sex if husband has extramarital sex	82.0	61.4	87.2	77.9
Percentage of men who justify wife's refusal to have sex if she is tired/ experience discomfort and pain	89.8	95.6	92.8	82.2
Wife insistence on use of condoms				
Percentage of men who justify wife's insistence on her husband using a condom when she does not want baby	94.3	97.3	96.0	69.7
Percentage of men who justify wife's insistence on husband using condom if she or her husband has any problem in genital areas	93.5	93.4	94.9	75.9

Attitudes towards women's sexuality contribute significantly to the making of masculine identities. Indeed, 'control' of female sexuality is the cornerstone of several kinds of gendered social ideologies. So, for example, a great deal of violence against women emanates from perceived transgression of social 'norms': we are well aware of the different forms of 'honour killings' across South Asia where the key aspect is women's assertion of their right to choose marriage or other kinds of partners. The sexual rights of women are, therefore, not only a matter of individual choice, but also an aspect that has significant social bearings upon their right to live a life free of violence. Further, given that the majority of survivors of violence against women that relate to sexuality have to do with younger women, this aspect also touches upon the sexual rights of the young. 'Sexual rights', as *'Exclaim! Young People's Guide to Sexual rights: an IPPF declaration'* (2011) points out, are distinct from reproductive rights in as much as the former 'relate to a person's sexuality, sexual orientation, gender identity, sexual behaviours and sexual health' (*Exclaim!* 2011:8). As the document further points out, 'every young person is entitled to personal fulfillment and to freedom from coercion, discrimination and violence, regardless of age, gender, race, ethnicity, religion, marital status, HIV status, sexual orientation, [and] health status'. Hence, given the substantial say that older men of the family and community have in the lives of young women in South Asia, an understanding of men's attitudes towards women's sexual rights is important social justice and human rights issue.

Sexuality, as the document *Sexual rights: an IPPF declaration* points out, is an integral part of every human being', and that, 'For this reason, a favourable environment in which everyone may enjoy all sexual rights as part of the process of development must be created' (Principle 1, p. 12). Hence, there are other aspects of sexual rights as they also need to be considered. For, paying attention to sexual rights is not only a matter of human rights of women, but also concerns development of capacities of men and women to take part in the processes of social justice. Hence, attention to sexual rights recognises that individuals are able to take full responsibility for their decisions and actions *(Sexual rights: an IPPF declaration)*. The capacity to take 'full responsibility' must mean that along with women, men are also required be involved in awareness-raising processes that relate to sexual rights.

A critical attention to masculinities also directs our attention to the issue of sexual rights and ways in which masculine cultures affect sexual rights – and hence human rights – of women.

4.5 Violence Against Women (VAW)

Vulnerabilities to sexual and reproductive health produced by inter-spousal violence have been well documented. It is recognised that men need to be actively involved in ending sexual violence in order to positively impact their partner's health as well as their own health. In this context, the study sought to understand men's attitude towards violence against women.

It was evident from the FGDs with men that violence against women in some form is prevalent in all the study countries. While in India majority of the violence was reportedly against wives, in Bangladesh and Pakistan it was reported to be against women in general inclusive of wife, sister, mother and mother-in-law. A few men in Pakistan mentioned that there is violence against non-familial women i.e., 'wives of other men' and 'domestic helps'. The primary perpetrators of VAW emerged as husbands and in-laws in India while in Bangladesh and Pakistan it included all male family members (father, brother, husband, son, father-in-law and brother-in-law). FGD participants in Bangladesh also mentioned that non-family members ('anti social elements like 'drunken youth, goons') also commit VAW.

Men's attitude towards domestic violence

In course of the quantitative study, the men were given certain situations and asked whether such situations justified wife beating. Specifically, the given situations were: wife goes out without telling husband; neglects house or children; argues with husband; refuse to have sex with husband; does not cook food properly; is 'unfaithful'; disrespects husband and; speaks to another man. The cross country data in *Table 4.5.1* suggests that men are more likely to justify wife beating in case of wife showing disrespect, wife arguing with husband, and wife being 'unfaithful' than in situations where wife goes out without telling husband, neglects house or children, refuses to have sex with husband, does not cook food properly or speaks to another man.

Table 4.5.1: Men's attitude towards violence against women

Percentage of men who justify hitting or beating spouse if:	India (N=383)	Bangladesh (N=365)	Nepal (N=374)	Pakistan (N=353)
She goes out without telling him	30.8	11.5	13.4	8.8
She neglects the house or children	33.7	15.6	16.3	5.9
She argues with him	35.5	29.9	21.7	8.2
She refuses to have sex with him	21.1	8.8	8.3	7.4
She does not cook food properly	25.1	2.2	4.8	0.6
She is 'unfaithful'	38.1	33.7	29.7	16.7
She disrespects him	46.7	39.5	26.2	20.7
She speaks to other man	23.0	7.4	4.8	12.5

Type of VAW

Men across board are most likely to justify wife beating if she disrespects him (India 46.7%, Bangladesh 39.5% and Pakistan 20.7%) excepting Nepal where wife beating is most likely to be justified if wife is 'unfaithful' (29.7%). Men are least likely to justify wife beating if she refuses to have sex with him (India 77.3%), or she does not cook food properly (Bangladesh 97%, Pakistan 97.7%, Nepal 92.5%) or speaks to another man (Nepal 93%). See *Table 4.5.1*. Focus group discussions with men revealed the type of violence against women in domestic as well as public spaces, men's perceptions regarding the reasons behind such acts and their perceptions regarding women's reactions to such violence. The FGDs focused on both domestic and inter-spousal violence as well are violence towards women in general.

Inter-spousal violence

Inter-spousal violence is evidently common across the countries but is reportedly more in Pakistan and Bangladesh. Besides, participants mentioned that female members of the family like mother-in-law, sister-in-law, mother and sister also commit VAW. The group discussions revealed that women are subjected to both physical and verbal domestic violence. In Bangladesh and India, participants mentioned that physical abuse against women was common in form of starving them. Participants in India also mentioned that women are often threatened about being thrown out of the home or in some cases were actually thrown out of home. As a participant in India said:

> *"Patni pasand na hone par maar peet kar ghar se bhaga dena".*
> *(If they don't like their wife then they beat her and throw her out.)*

Few men from Bangladesh also reported about sexual violence in form of forced sex by husband (*"jor kore sohobas kora"*). Common reasons for VAW in Bangladesh and India were cited by the FGD participants as addiction, dowry and sexual violence. In the words of FGD participants from India:

> *"Patni saath me dahej nahi laane se". (If wife does not get dowry with her)*

> *"Sex ka bhukha hai so pithta hai". (Husband is sex starved and so beats wife)*

A common reason for wife-beating as cited in India and Pakistan (more prominently in Pakistan) is suspicion about the woman's moral character and relationships with other men. A FGD participant in India cited the reason for VAW as:

> *"Mahila ke upar shaq hona ke kisi aur ke saath sambandh hai".*
> *(Gets suspicious of the woman that she has a relationship with someone else)*

Non-performance of domestic responsibilities by women, especially not cooking on time or not serving hot meals, not following husband's orders etc was cited in India as common reasons for violence against women. FGD participants in India also articulated that husbands beat their wives if they do not 'adjust' with their family members, especially with in-laws. Some of the reasons of violence against woman were articulated by the participants as follows:

> *"Purush jab kaam karke aate hai to waqt par khana nahi banaya".*
> *(When the husband returns home from work and she does not serve food)*

"Ghar me saaf safai nahi kiya" etc. (Has not cleaned the house)

"Parivar ko saath lekar nahi chalne par". (Does not adjust with the family)

The FGD participants expressed that husbands tend to transfer their anger and frustrations at the work place or anger on children on to their wives in form of physical abuse. In Pakistan, men voiced that reasons such as suspicions of wife having a relationship with other men or wife refusing to have sex commonly lead to violence against women. Some of the other reasons of domestic violence mentioned were, *"bina bataye mayke jana"* (visiting maternal home without permission), *"apni marzi se samaan kharidna"* (purchasing things on their own), husbands not liking them, men's superiority complex, financial crisis, property related issues etc.. In Nepal men said that VAW is almost a common social practice and an accepted form of male behaviour.

The traditional marriage form in South Asia is the bedrock of asymmetrical gender relations and is premised on masculine superiority. It is also the site for the normalisation of certain types of male behaviour towards women. SRH programmes that seek to make a substantial difference to women's lives must address ideas of masculine entitlement and women's position within the household as wives and daughters-in-law.

VAW in public spaces

Apart from violence in domestic spaces, the FGDs focused on common forms of VAW in public spaces. The most frequently mentioned VAW among women was reported to be eve teasing. Along with eve teasing, participants in Bangladesh and Nepal also reported about physical assault e.g., *"sharirik bhabe lanchito kora"* and restricting women's movement in the community. In India the forms of VAW mentioned were eve teasing and unwanted touch/molestation in public transports or public places. Following on from the discussion earlier on the public/private dichotomy, the idea that public sphere is a 'masculinised' one is the starting point for exploring relationship between gendered violence and publicness. The kinds of issues we need to explore within this context have already been alluded to above. These throw light upon the causes and nature of gender-based violence in public spaces, and the new emerging issues in urban and semi-urban contexts that are leading to gender-based violence in public spaces.

One of the first things we might say about violence against women in public spaces is that it relates to ideas of 'natural' claims to such spaces. That is to say that once the 'private' is defined as the (inferior) complement to the 'public', some people are seen to more 'properly' belong to public spaces than others. The most straightforward way of elaborating upon this is to say that heterosexual men are seen to have a greater (if not exclusive) claim upon public space. But, of course, it is not as simple as that and a more nuanced understanding is required. So, in order to introduce a level of complexity into our understanding, we might say that in India, for example, upper caste middle-class heterosexual men are likely to have greater sway over public spaces as compared to women, lower caste non-middle class men and non-heterosexual men (in as much as the latter category is easier to 'identify'). Similar kinds of nuances can be introduced for other countries in South Asia. Linked to this aspect is the popular perception that there are specific conditions under which men

and women may access public spaces. While it is generally understood that men's access to public spaces need not be tied to a 'purpose' (that is, carrying out specific tasks), the idea of women loitering in such spaces becomes both incomprehensible and condemnable (Phadke and Ranade 2011). A recent study carried out in Mumbai that asked respondents to indicate how men and women use space summarises its findings as follows:

… it is always men who are found occupying public space at rest … Women, on the other hand are rarely found standing or waiting in public spaces—they move across space from one point to another in a purposeful movement … Women occupy public space essentially as a transit between one private space and another. (Ranade 2007:1521)

The idea of the necessity of purposeful activity by women is one that emanates from many sites of which the family is one of the most powerful. It is, perhaps, also the most stringent in its enforcement of the rule of 'purpose'. And, just as significantly, we should be mindful of how—in addition to gender—different kinds of social attributes come into play in restricting or permitting physical mobility. Further, the discourse of women and purpose is reinforced by a complimentary formulation that refers to the 'balance' a working woman must achieve between her paid work and household responsibilities. So, a woman's 'paid work [is] not objectionable, provided she [takes] good care of her household responsibilities' (SWSJU 2010:38). In order to achieve this 'balance', however, it becomes imperative that women spend only that time in the public sphere that serves the purpose of carrying out the responsibilities of paid work, thereafter retreating to the home for other duties.

To return the FGD, participants across three countries marked the main perpetrators of community level VAW were marked as 'boys and men'. The participants in Bangladesh emphasised that 'local muscle men and political leaders' as well as 'religious fundamentalists' are also involved in VAW. Likewise in India, 'co-workers' and 'anti-social elements' were mentioned as persons involved in VAW.

Though participants recognised that men carry out violence in form of sexual harassment/ abuse towards women in social spaces, ironically the women themselves get blamed for being abused. For instance, men in India said that generally the women face sexual harassment in public spaces if they are 'physically appealing'. The FGD participants in India voiced that woman who dress 'inappropriately' (wears fancy or short clothes, make-up, commutes alone etc.), are the primary targets of sexual harassment. In the opinion of the men participating in FGDs, women should stay within their 'limits' to avoid getting abused ("*mahila ko auqat me rahna chahiye*") and they should be obedient to men. They expressed that women provoke men by not wearing 'socially acceptable' clothes. In their own words:

> *"Sundar mahila ko dekhkar achcha lagta hai aur uttejna hoti hai".*
> *(They get excited seeing a beautiful woman) India*

> *"Mahila jo chota kapda pahanti hai unhe dekhkkar chedne ka man karta hai".*
> *(Women in short clothes arouses the desire to tease/abuse)*

"Mahilayein chote kapde pahankar chedchad ko nyota deti hai".
(Women invite trouble/abuse by wearing short clothes)

Other reasons cited in India included peer pressure, influence of television, men's superiority complex etc. Similar views regarding the negative influence of television promoting such behaviour in men was echoed in Pakistan ("*T.V. ne ladkown ko bigada hai*" *T.V. has spoiled the boys*). Few men from India and Bangladesh expressed that men get sexual pleasure by teasing or abusing women publicly. Participants in Bangladesh voiced that men sexually abuse women/or are violent towards them either to fulfill their sexual desire or to dishonour a woman in order take revenge. They also mentioned that for some men it is a misuse of one's political power. In their own words men resort to violence against women for the following:

"Jauno akankha metanor jonnyo". (To satisfy sexual desires)

"Premer prosthabe raji na howay". (Women do not accept their proposal)

"Rajnoitik probhab khatanor jonnyo". (To misuse/take advantage of political power)

In Pakistan, FGD participants were of the opinion that eve teasing is carried out to attract the woman's attention or to settle personal rivalries with some male members of the woman's family. Some participants expressed that men abuse women because they think that a woman is subordinate and inferior to men. They used the expression *"mahila ko joote samajhte hai"* (a woman is like a shoe) to illustrate the general attitude of men towards women.

The FGD participants in Nepal voiced that women need to protest against such abuse. In Pakistan, FGD participants were of the view that since the society is male dominated, this in turn legitimises VAW and that it can only be stopped by more men participating in different women's development programmes. Similarly in Bangladesh men recognised the fact that VAW takes place due to lack of awareness among men and that men need to be sensitised on the issue.

VAW, while it affects both the old and the young, tends to involve a greater proportion of young women as victims. As well, a great deal of violence relates, in one way or another, to sexuality. Hence, it might involve passing lewd comments of sexual nature, or physical violence at perceived transgressions of family and community norms of sexuality. In this way, it is an issue which can take the form of physical as well as emotional abuse, and also impinges upon the sexual rights of women.

Men's perception of women's response/reaction to violence against them.

A common perception across the countries is that women in general do nothing in response to domestic violence/sexual harassment in public. As articulated by a discussant, *("mahilayein chup rahti hai, sahti rahti hai" women keep quiet and tolerate)*.

One of the commonly mentioned responses to VAW in both India and Bangladesh were crying

or not taking food, ("*kuch mahilayein roti hai*", "*khud khana nahi khati hai*") transferring the anger frustration on to the children or going off to their maternal home. Discussants in Bangladesh voiced that women facing domestic violence lose interest in life or lose their mental balance ("*dushchinta kore, bhoy pay, paagol hoye jaay*").Studies show that violence can affect self esteem, mental health and also have long term effects on reproductive health (Ganguly 2004).

Women frequently deal with VAW by justifying the act especially in case of inter-spousal violence and thereby normalising it. For instance as mentioned by a FGD participant in India, a woman who is physically abused by her spouse may justify the act by saying that 'he beats me but also loves me' (*"maarta hai to pyar bhi karta hai"*).

As it emerged from the discussion, women filing FIR (First Information Report) in response to domestic violence is a rarity. Pakistan came across as the only country where a few participants mentioned that some women try to resist domestic violence and are vocal about it by complaining to other family members. In India, participants mentioned that most women who get sexually harassed in public spaces choose not to respond to abuse against them. This is not an unsurprising outcome in a society where male notions of what constitutes 'violence' frequently guide women's recognition of it. So, a woman who has faced harassment may choose to overlook it if, say, her father suggests that it is too 'trivial' a matter, or that 'girls must learn to live with a certain degree of harassment'. This may happen in those instances where the man feels unable to act to redress the 'insult' to 'family honour', and it seems better to not do anything rather than risk further humiliation. What comes into play in such instances is not so much a consideration of the feelings of the woman but, rather, various contexts of male honour. Needless to say, this has serious implications as far as sexual rights of are concerned, including the right to equality, the right to life, freedom from harm and the right to free expression *(Sexual rights: an IPPF declaration)*

In light of the above, it emerged from the discussions that popular perceptions of feminine behaviour in the context of sexual harassment in turn justifies VAW. For instance, participants voiced that women who fight back are perceived to be of amoral character while the ones who remain silent are seen as being from respectable families *("bigdi badchalan aurath zyada virodh karti hai"* or *"izzatdar mahilayein virodh nahi karti aur chupchap chali jati hai").*

Similar perceptions are evident in case of Pakistan were participants reported that women hardly share experiences of being sexually harassed with anyone for the fear of social stigma. In Bangladesh, women who are routinely harassed are reportedly forced to leave the area and relocate in a different place while some give up studies and stay at home. It must be mentioned here that participants in Bangladesh were the only ones who voiced that women who are forced to give up activities or being in public spaces are deprived of their fundamental rights. These attitudes reflect the fact that violence against women is frequently understood – by men as well as many women – through a masculine lens. They also impact upon young women's 'right to participation' (*Exclaim!*, p. 18) through effectively narrowing their 'approved' sphere of activities to the 'private' and the domestic.

Women's perceptions of VAW

Women's perceptions on violence against them in domestic or public space were sought through group discussions. An analysis of FGDs with women reveals perceptions similar to that of men. The participants expressed that most women bear with the violence as long as they can. Sometimes women complain to other family members or get someone as a witness. A few women retaliate by shouting at the men and few others try to hit back in response to physical assault. Some other common reactions to domestic VAW included beating children, not taking food, leaving their spouse and going to their parental home. However, as gathered from the FGDs, women rarely seek the option of divorce for the fear of being socially stigmatised.

The women discussants also reiterated the men's perceptions that women generally do not respond to eve-teasing or other verbal abuses in public spaces for the fear of social shame. Some of them may complain to family members or be forced by their family members to give up studies/work and stay indoors. Some participants mentioned that a small proportion of women may retaliate by verbally abusing the perpetrators or by gestures such as showing a slipper – 'chappal'. In this context a FGD participant in India mentioned:

> *"They remain silent or do not react/walk away silently in response to violence while some fight back by 'either screaming or beating the person with slippers".*

Violence against women in both public and domestic spaces is structured around ideas of male honour and uncontrollable masculine sexuality that is easily 'aroused' by women who dress or behave in a particular manner. These attitudes are frequently internalised by women who may consider it 'shameful' for their families to talk about violence addressed towards their person.

4.6 Gender Equitable Men (GEM)[1] scale

GEM scale items

The GEM Scale covered a total of 26 attitude questions adapted for South Asian context, broadly based on issues such as sexuality and reproductive health, gender role in home and child care, decision making, masculinity and violence. For each question, three answer choices were provided: agree, partially agree and do not agree. *Table 4.5.1* gives the percentage of men agreeing with the GEM scale items.

The table below shows that a fairly moderate proportion of men across the countries are likely to have a positive attitude towards areas related to sexuality and reproductive health. Among them, Pakistan has the lowest proportion of men with positive attitude towards these issues. Comparatively, a lower proportion of men have positive attitude towards gender equity with regards to household related work and child care. However, (with the exception of Pakistan) a fairly large proportion of men perceive it to be important that a

1 The Gender Equitable Men (GEM) Scale is a research instrument developed by Instituto Promundo and the Population Council Horizons Programme. For more details, see *http://www.popcouncil.org/Horizons/ORToolkit/toolkit/gem1.htm*

father is present in the lives of his children, even if he is no longer with the mother. A large proportion of men are likely to have a positive attitude towards gender equity in decision making on issues of having children and contraceptive use.

Across the countries, presence of culturally dominant notions of masculinity in varying degree was evident. Overall, more men in India in comparison to the other countries agreed to all the GEM scale items regarding masculinity, particularly: 'a man needs to be tough', 'needs to participate in games to win', 'men should be embarrassed if they are unable to get an erection during sex', 'men should have the respect and admiration of everyone who knows them', 'men are always prepared to take risks'. A lesser proportion of men in Pakistan held similar views followed by Nepal and Bangladesh. On the whole, men across the countries are likely to have a correct attitude regarding violence i.e.; a sizable proportion disagreed to the items on violence against women. However, nearly two third in India and Nepal perceive that violence is appropriate to defend one's reputation. See *Table 4.6.1*

Table 4.6.1 GEM scale items

Percentage of men who agreed with the GEM scale items	India (N=383)	Bangladesh (N=365)	Nepal (N=374)	Pakistan (N=353)
Sexuality and reproductive health				
It is the man who decides what type of sex to have	46.0	13.4	17.9	53.8
Men need sex more than women do	39.2	39.5	46.0	46.5
Men are always ready to have sex	40.5	21.4	28.9	32.6
You don't talk about sex, you just do it	28.2	12.6	52.7	26.6
Women who carry condoms with them are "easy"	22.7	25.8	29.9	28.3
A man needs other women, even if things with his wife are fine	15.7	13.4	23.3	21.8
I would be outraged if my wife asked me to use a condom	28.5	1.4	11.8	12.2
In my opinion, a woman can suggest using condom just like a man can	90.1	69.3	83.4	52.1
It is a woman's responsibility to avoid getting pregnant	38.1	12.1	17.9	23.8
A couple should decide together if they want to have children	92.2	75.9	84.8	64.6
Gender role in home and child care				
Changing diapers, giving kids a bath, and feeding the kids are the mother's responsibility	57.2	59.5	38.0	53.8
A man should have the final word about decisions in his home	62.7	26.3	35.8	54.7
A woman's most important role is to take care of her home and cook for her family	66.6	54.0	55.9	70.3
It is important that a father is present in the lives of his children, even if he is no longer with the mother	86.4	70.4	67.1	48.7
Decision making				
A couple should together decide on having children	92.2	75.9	84.8	64.6
A man and a woman should decide together what type of contraceptive to use	90.1	80.5	88.5	60.1
Masculinity				
It is important to have a male friend with whom you can talk about your problems	54.3	65.8	52.9	50.4
If a man hurts himself, he should try not to let others see he is in pain	41.8	50.1	42.2	41.1
To be a man, you need to be tough	80.2	44.7	42.2	61.2

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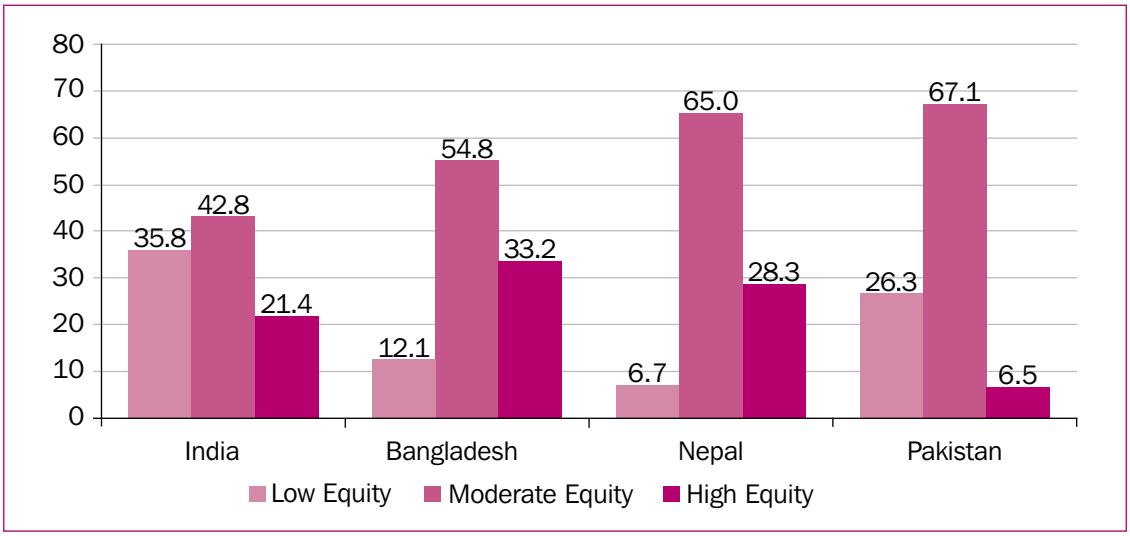
Percentage of men who agreed with the GEM scale items	India (N=383)	Bangladesh (N=365)	Nepal (N=374)	Pakistan (N=353)
Men participate in games to win	79.9	61.6	45.5	51.0
Men should be embarrassed if they are unable to get an erection during sex	76.8	41.4	40.6	71.4
Men should have the respect and admiration of everyone who knows them	82.2	70.4	75.4	64.3
Men are always prepared to take risks	91.1	57.8	54.5	66.0
Violence				
A woman should tolerate violence in order to keep her family together	44.6	23.6	29.1	22.9
If a woman cheats on a man, it is okay for him to hit her	42.3	25.5	14.7	19.8
It is okay for a man to hit his wife if she won't have sex with him	24.3	4.7	10.7	13.3
There are times when a woman deserves to be beaten	24.3	28.2	6.7	19.3
If someone insults me, I will defend my reputation, with force if I have to	64.0	43.3	63.4	37.4

GEM scale scores

GEM scale scores were categorised into "high equity", "moderate equity", and "low equity". The figure below gives the overall scores of GEM scale. The scale shows more men in India and Pakistan support inequitable gender norms (low equity) in comparison to Bangladesh and Nepal where men are primarily distributed across moderate and high equity.

Figure 4.6.1: GEM scale scores



GEM scale scores on various indicators

The GEM scale scores were cross tabulated with various indicators such as attitude towards issues such as contraceptive use, emergency contraception, pre natal and post natal care, STI/HIV & AIDS and violence.

Men who have a favourable attitude towards contraceptives in India and Pakistan were mostly low to moderately equitable while in Bangladesh and Nepal they were found to be moderate to highly equitable. Men who were currently using contraceptives were mostly in the moderate equity category across the countries. With regards to emergency contraception there was not much difference across the equity categories.

The data shows that most men who accompanied wife to prenatal care think that 'women should have regular check up even if she feels fine during pregnancy' and; 'women should have post-natal check up after delivery' were moderately equitable. Proportion of men favourable towards abortion of unwanted pregnancy is distributed across moderate and high equity categories with the exception of Pakistan where they are spread over low and moderate equity.

Overall, proportion of men who had knowledge about STI and those who think that men have to undergo check up if wife has STI were primarily distributed across moderate and high equity. Proportion of men who reported having any symptoms in the past 12 months was mostly in the moderate equity category. With the exception of Pakistan, men who perceive that a boy should be tested before he gets married were primarily of moderate equity followed by high equity. In Pakistan men with similar perspective were mostly from moderate equity category.

Men who justified wife beating under any circumstances were primarily from low equity category and to some extent from moderate equity category in India, in Bangladesh and Nepal they were primarily from moderate equity while in Pakistan they were spread across moderate and low equity categories. Men with a positive attitude towards women's refusal to have sex and women's request for using condom were distributed across the equity categories in India, were primarily moderately and highly equitable in Bangladesh and Nepal and spread across moderate and low equity categories in Pakistan. See *Table 4.6.2*.

Table 4.6.2: Cross tabulation of GEM scale scores on key indicators

	India (N=383)	Bangladesh (N=365)	Nepal (N=374)	Pakistan (N=353)
Percentage of couple currently using contraceptives				
GEMS	*	-	*	-
Low equity	39.4	75.0	40.0	41.9
Medium equity	50.6	79.0	62.1	53.6
High equity	58.5	80.2	66.0	60.9
Percentage of men who accompanied wife to prenatal care†				
GEMS	*	*	*	*
Low equity	55.5	50.0	28.0	50.5
Moderate equity	73.2	66.5	56.0	59.9
High equity	89.0	80.2	58.5	69.6
Percentage of men who think that women should have regular check up even if she feels fine during pregnancy				
GEMS	*	*	*	-
Low equity	79.6	68.2	76.0	86.0
Medium equity	93.9	82.0	93.0	88.2
High equity	100	92.6	100	95.7

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	India (N=383)	Bangladesh (N=365)	Nepal (N=374)	Pakistan (N=353)
Percentage of men who think that women should have postnatal check up after delivery				
GEMS	*	*	*	-
Low equity	72.3	63.6	60.0	84.9
Medium equity	87.8	75.0	88.5	84.0
High equity	91.5	87.6	97.2	82.6
Percentage of men who have knowledge about STI				
GEMS	*	-	*	*
Low equity	38.0	59.1	32.0	23.7
Medium equity	57.9	70.5	60.9	44.7
High equity	85.4	70.2	75.5	47.8
Percentage of men who think that a boy should be tested for HIV before he gets married				
GEMS	*	*	-	-
Low equity	80.2	85.4	60.0	57.3
Medium equity	84.4	78.0	76.4	64.1
High equity	98.8	59.2	76.2	50.0
Percentage of men who agree that a husband is justified in beating his wife				
GEMS	*	*	*	*
Low equity	75.9	84.1	68.0	43.0
Moderate equity	51.8	63.5	54.7	24.9
High equity	37.8	39.7	24.5	17.4

*P<0.05, Chi Square test; † for married respondents whose wife was pregnant at some point of time

4.7 Communication with family members

Communication is a key element of heath seeking behaviour. Men's communication with family members was assessed with reference to a set of questions: i) person/s most likely to advice them on general issues such as social behaviour with wife's family as well as regarding issues such as family planning, outcome of sexual relation with wife and planning/delaying the birth of first child; ii) person/s men are most likely to talk to about reproductive health problems as well as general issues such as taking a job.

The study specifically tried to assess couple communication on the basis of responses to questions relating to reproductive health problems such as nocturnal emission and utheral discharge and general issues such as employment/job related decisions.

As evident from the table below, person/s most likely to advise men and person whom men seek to discuss various issues differs according to the topic. Men in Bangladesh and Nepal are likely to discuss general topics like appropriate social behaviour towards in-laws with family members than with non-family members while in India and to some extent in Pakistan, men are more likely to discuss such issues with their peers.

The data shows that while men are more likely to talk to their friends than family members (mother/father) on the outcome of sexual relationship with wife, they are likely to discuss family planning with both family and non-family members. Overall, men in India are more likely to discuss any of these topics with their friends than family members. Both family and non-family members are likely to advise them on the need to have the first child soon. Again, India is the exception with nearly four fifths reporting that they get such advice

from their friends. Men in India get advice on delaying the first child primarily from friends and to some extend from their mother. In Nepal and Pakistan, men receive similar advice mostly from their friends while in Bangladesh, family members other than parents as well as friends give such advice.

When it comes to their own sexual and reproductive health problems, couple communication is evident as men are most likely to discuss their problems such as nocturnal emission and urethral discharge with their wife followed by health providers (except in Pakistan where men are more likely to discuss such topics with health providers than wife). Men are also likely to discuss non-health issues such as taking up a job mostly with their spouse. See *Table 4.7.1* below.

Table 4.7.1: Communication with family members

	India (N=383)	Bangladesh (N=365)	Nepal (N=374)	Pakistan (N=353)
Percentage of men who received advice on appropriate behaviour with wife/in-laws	19.8	26.0	24.9	19.0
Person who advised				
Mother	30.3	54.7	60.2	16.4
Father	23.7	25.3	28.0	34.3
Sister/Sister-in-law	15.8	10.5	15.1	0.0
Brother/Brother-in-law	9.2	6.3	7.5	4.5
Other female relatives	1.3	17.9	4.3	0.0
Other male relatives	14.5	3.2	2.2	19.4
Friends	56.6	29.5	20.4	49.3
Neighhbours	5.3	5.3	-	-
Others	1.3	2.1	-	-
Percentage of men who received advice on outcome of sexual relation with wife	14.6	60.8	21.4	19.3
Person who advised				
Mother	3.6	0.5	2.5	4.4
Father	3.6	0.9	2.5	14.7
Sister/Sister-in-law	8.9	10.8	0.0	0.0
Brother/Brother-in-law	0.0	1.8	0.0	2.9
Other female relatives	1.8	13.5	1.3	0.0
Other male relatives	8.9	18.5	1.3	14.7
Friends	80.4	59.9	97.5	77.9
Neighhbours	3.6	1.8	0.0	0.0
Others	1.8	0.0	0.0	0.0
Percentage of men who received advice on the need to have child soon	8.1	11.0	13.1	10.8
Person who advised				
Mother	19.4	47.5	49.0	26.3
Father	9.7	15.0	20.4	34.2
Sister/Sister-in-law	6.5	10.0	0.0	2.6
Brother/Brother-in-law	3.2	2.5	0.0	0.0
Other female relatives	3.2	10.0	2.0	7.9
Other male relatives	12.9	7.5	2.0	7.9
Friends	77.4	52.5	44.9	47.4
Neighhbours	6.5	0.0	2.0	0.0

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	India (N=383)	Bangladesh (N=365)	Nepal (N=374)	Pakistan (N=353)
Percentage of men who received advice about delaying first child	15.9	46.0	19.0	3.4
Person who advised				
Mother	26.2	6.5	7.0	0.0
Father	23.0	3.0	2.8	16.7
Sister/Sister-in-law	6.6	12.5	1.4	0.0
Brother/Brother-in-law	0.0	4.2	4.2	8.3
Other female relatives	1.6	30.4	1.4	0.0
Other male relatives	16.4	19.0	7.0	8.3
Friends	57.4	29.2	81.7	66.7
Neighbours	0.0	3.0	2.8	0.0
Others	6.6	1.8	0.0	0.0
Person with whom men are most likely to talk about a job				
Mother	43.1	32.9	13.9	17.6
Father	51.7	14.5	19.8	23.8
Sister	8.1	4.4	0.5	2.3
Brother	5.0	2.2	0.3	10.8
Other relations	0.3	0.5	2.1	3.4
Friends	15.1	6.8	0.8	13.6
Health care provider	1.0	1.6	3.7	1.4
Wife	68.7	61.6	83.2	68.0
Mothers/Sister-in-Law	0.3	0.8	0.0	0.3
Father/Brother-in-Law	0.3	0.0	0.0	0.3
Locally influential person	0.3	0.0	0.0	0.3
Nobody	1.0	0.3	1.6	5.7
Others	0.8	0.0	0.8	1.4
Person with whom men are most likely to talk about nocturnal emission				
Mother	0.8	0.3	1.1	0.8
Father	2.9	0.3	0.8	4.2
Sister	0.0	0.3	0.5	0.0
Brother	0.0	-	0.5	3.7
Other relations	0.3	4.4	0.3	1.1
Friends	24.5	15.3	12.3	20.4
Health care provider	33.7	7.4	31.0	50.1
Wife	66.1	66.3	59.1	38.8
Mothers/Sister-in-Law	0.0	2.2	0.0	0.3
Locally influential person	0.3	-	0.0	0.0
Nobody	3.7	6.3	3.5	4.8
Others	1.0	-	0.8	0.8
Person with whom men are most likely to talk to when experiencing urethral discharge				
Mother	1.0	6.0	0.0	0.8
Father	3.1	4.1	0.0	4.0
Sister	0.0	0.5	0.3	0.0
Brother	0.3	0.0	0.0	2.8
Other relations	0.5	1.9	0.8	2.5
Friends	24.8	16.7	7.2	17.0
Health care provider	43.9	23.6	37.5	51.0
Wife	65.8	52.6	59.2	41.6
Mothers/Sister-in-Law	0.3	1.4	0.0	0.0
Locally influential person	0.8	0.3	0.0	0.0
Nobody	1.6	5.8	3.5	3.1
Others	1.0	0.0	0.8	1.1

CHAPTER 5

PARENTING

Men are socialised into gender roles which shape the way they perceive parenting. It has been well documented that child care is seen as a woman's task and the contribution of men as parent in direct child care is much less than that of a mother. Cultures of masculinity in South Asia play a considerable role in defining attitudes towards parenting. There is a specific understanding of parenting as far as fathers and daughters are concerned. This relates to the fact that relationship between fathers and daughters is primarily seen as one of protection and control. In this context, fathers are expected to protect daughters from 'harm', as well as exercise a controlling influence over their sexuality. These attitudes towards parenting are derived from more general perspectives on gender. This chapter looks at men's participation in bringing up children and their role in parenting.

The men participating in the study were asked about the time they spend with their children in various activities in terms of 'often', 'now and again' and 'never'. Overall, the data suggests that men are to some extend involved in the upbringing of their children but the level of involvement varied across the countries. Among the four countries, men in Pakistan are least likely to be involved in the lives of their children on more than one activity.

The men were asked about how much time they spend playing with their children. *Table 5.1.1* shows that more men in Bangladesh (67.2%) and Pakistan (57.1%) are 'often' likely to play with their children than in India (33.9%) and Nepal (36.6%). Two fifths of the men in Bangladesh are likely to often involve in physical exercise or play outdoor games with their children while two thirds in India, nearly half in Nepal and slightly more than one third in Pakistan are likely to do so now and again. A small proportion of men are likely to speak about personal matters with their children. More men in India are likely to now and again talk about personal matters with their children than in other countries while men in Bangladesh are least likely to do the same.

To understand men's attitude towards and involvement in domestic work related to child upbringing, they were asked whether they would cook and wash clothes for their children. As informed from the data, men are more likely to be engaged in spending time with children for physical activity/play and less likely to be involved in child care in terms of performing domestic chores.

While about two fifths of men in Bangladesh were willing to cook for their children, a negligible proportion of men were willing to do so in the rest of the countries. While more than two thirds in Nepal and nearly half in India are likely to cook for their children now and again, more than half in Pakistan are likely to never cook for their children. Similarly, more men in Bangladesh are often likely to wash clothes for their children (31%) as compared to the rest. While 60.3% of men in Nepal and 39.7% men in India are likely to wash clothes

for their children now and again, little less than three fourths of the men in Pakistan are likely to never wash clothes for their children.

Further, the men were asked whether they would like the role they perform in their child/children's life to be bigger or less in some ways. A large majority in India mentioned that they would like to perform a bigger role in their children's lives while the proportion of men with similar views was slightly less in Pakistan followed by Bangladesh. In Nepal where men reported to be more involved in various activities than their counterparts in the other three countries, two thirds were of the view that they would like their role to be the same.

Table: 5.1.1 Attitude towards parenting

Men's attitude towards parenting	India (N=383)	Bangladesh (N=365)	Nepal (N=374)	Pakistan (N=353)
Play with children at home	(354)	(351)	(352)	(329)
Often	33.9	67.2	36.6	57.1
Now & again	59.3	24.8	51.4	31.9
Never	6.8	8.0	11.9	10.9
Talk about personal matters with their children	(353)	(351)	(354)	(327)
Often	24.4	29.6	15.0	38.5
Now & again	61.8	6.0	46.3	34.6
Never	13.9	64.4	38.7	26.9
Do physical exercise or play games outside home with their children	(352)	(353)	(353)	(328)
Often	22.7	40.5	11.9	29.3
Now & again	61.6	24.9	47.9	36.0
Never	15.6	34.6	40.2	34.8
Cook or fix food for children	(353)	(352)	(350)	(329)
Often	7.4	41.5	15.7	9.1
Now & again	49.6	4.3	66.3	31.0
Never	43.1	54.3	18.0	59.9
Wash clothes for children	(350)	(352)	(348)	(328)
Often	3.4	31.0	13.2	6.4
Now & again	39.7	17.9	60.3	21.3
Never	56.9	51.1	26.4	72.3
Role that the respondents think they have to play in the lives of their children				
Bigger	87.7	73.7	23.5	77.6
The same	7.3	23.3	66.6	14.2
Less in some way	1.6	2.5	4.5	2.3
Don't have a role	3.4	0.5	5.3	5.9

The qualitative part of the study also focused on men's involved in early child care. As discussed earlier in Chapter 4, men do not perceive a substantial role in neonatal care (up to one month). In case of slightly older children upto 5 years of age, men see their role more as that of a provider who brings books and clothes for children and arrange for their admission in schools. The FGD participants pointed out that men also play a role in teaching children good habits or taking care of them when they are crying, spending their leisure time with children by doing various activities like playing with them, taking them on a bicycle ride etc. As it emerges from the discussions, men perceive a lesser role in the upbringing of a girl child as they feel that girls communicate their problems only with their mothers while the father's role is to see that the child does not get involved in wrong activities.

CHAPTER 6

SERVICE PROVIDER'S PERSPECTIVE ON MEN'S SRH NEEDS AND VULNERABILITY

The focus of reproductive health services in South Asia as elsewhere has been on women, by and large overlooking the reproductive needs and concerns of men. One of the key focus areas of IPPF's programme is on developing the conceptual understanding of men's sexual and reproductive health and rights and their role as partners among staff and volunteers. In this context the study sought to explore service providers' perceptions about SRH needs and vulnerability of men. This chapter presents the perceptions of service providers regarding the sexual and reproductive health needs of men and the nature of health care service offered to male clients.

6.1 Profile

The study covered 14 health providers in India and Bangladesh, 11 in Nepal and 16 in Pakistan. While the health providers in India and Pakistan were primarily men (mostly MBBS) in Bangladesh and Nepal they were mostly women (nurses). The service providers across the countries with exception of Nepal were mostly married. Service providers in Nepal had a younger age profile in comparison to those in the other three countries.

6.2 Interaction with male clients

Level of interaction

It is apparent from the study that on specific issues related to reproductive health, service providers are mostly frequented by married women followed by married men. The frequency of interactions between service providers and male clients was reported to be very high in Pakistan and India followed by Bangladesh while the frequency of interaction is comparatively lower in Nepal. Overall, service providers reported more interactions with younger female clients than younger male clients across all age groups. The mean number of female clients reportedly reached by the service providers in the last one month outnumbered the mean number of male clients, with the exception of India.

Information dissemination on specific issues

To understand the type of information given to male or female clients, the service providers were asked whether they provide specific information on the following topics: safer sex, family planning, maternal health/care during pregnancy, HIV prevention and treatment, sexually transmitted infections, menstrual regulation/abortion/post abortion care, gender based violence and nutrition. Overall, the provision of information on the above issues is skewed towards the married than the unmarried. The data shows that information on the above issues is more frequently provided to married women than to married men and the same

pattern is observed among unmarried women and men. The only exception is India which reported a slightly higher frequency of information dissemination among boys than girls.

Alternately, this indicates that men (married and unmarried) may not be seeking services from these providers for sexual reproductive health information as actively as married/unmarried women. For instance, Bangladesh and Nepal, where the service providers interviewed were female nurses; information on most sexual and reproductive health related issues is more frequently accessed by young girls than boys while the service providers in India – mostly male doctors, have a slightly higher interaction with male clients than female. In case of Pakistan where most providers interviewed were male doctors, the interaction with female and male clients varied on the topics.

Among all the issues, counselling on gender and violence emerged to be low on priority. Health service providers mostly provide information individually to the clients. They mentioned that they discuss sexuality related topics with young married and unmarried females but are more comfortable with married women. They reported to be more or less equally comfortable discussing sexuality related topics with married and unmarried young males.

Knowledge of HIV/SRH programmes

The service providers were not universally aware of services/programmes providing HIV/SRH related information and service to males. More service providers in Bangladesh and India than in Nepal and Pakistan were aware of such services or programmes. While service providers in India and Bangladesh specified the programme as 'counselling and treatment camp', providers in Nepal and Pakistan specified the programme to be 'government organisation scheme'.

Common SRH problems reported by men

Men's SRH related problems were reported by more providers in India and Pakistan than in Bangladesh and Nepal. This difference may be linked to fact that most providers interviewed in India and Pakistan were male and may have more male clients.

The most frequently reported SRH problems across the countries were symptoms such as frequent urination/incontinence, burning sensation/pain during urination (Bangladesh, India Pakistan), bumps or sores on genitals, discharge from genitals (Nepal) and; sexual function related problems such as ejaculation before coitus, unable to maintain an erection/ impotence, pain during sex, loss of semen/nocturnal emission, loss of semen before and after urination, shortened duration of sexual intercourse (India and Pakistan).

6.3 Types of services provided

To understand the range of services provided, the study focused on various reproductive and sexual health services offered by the health service providers in the past three months. This included services such as contraceptive counselling, contraceptive methods to newly married couples as well as unmarried males and females; abortion/post abortion services to young married females; and counselling and referral service for STI to young married males and females and; HIV & AIDS counselling and services to young married male and females.

Contraceptive counselling and services

It emerged that the service providers more frequently counsel on and provide contraceptives to married men than unmarried men/boys. There are some attitudinal barriers in recommending contraceptive use before first birth to newly married couples as most providers said that they 'sometime' advise newly married couple to use contraceptive before first birth. Counselling on dual protection to young married couple is not universally practiced. Incidentally, the number of service providers providing contraceptive services to unmarried females was much higher than those providing to unmarried males. This should be considered an extremely serious issue and contextualised within the framework of prevailing notions of masculinity. Men – both married and unmarried – have far greater leeway in terms of refusing to use contraception. This relates both towards the attitude that condoms 'reduce' sexual pleasure, and that it is usually left to women to bear the responsibility for 'safer sex'. Therefore a woman is likely to suffer far greater stigma on account of an out-of-wedlock pregnancy than a man. This is a specific example in which cultures of masculinity and sexuality are related. The link also demonstrates that men's attitude towards contraception may be harmful not only for women but also for men.

Abortion/post abortion related services

Less than half the providers in India and Nepal reported to have provided abortion/post abortion related services to married young females and a smaller number provided these services to unmarried females in the past three months. Provision of abortion service was also reported by a few providers in Bangladesh and Pakistan. As abortion is restricted in these countries, it raises concerns about the safely and quality of abortion service and post abortion care.

STI and HIV & AIDS counselling and referral services

The study highlights that in the past three months more young married females have received STI counselling and referral services than young married males, except in India where more young married males accessed these services than young married females. This is in line with the earlier findings that service providers in India reportedly provide sexual and reproductive health information more often to boys than girls. A similar trend is seen in case of provision of STI diagnosis to married young males and females.

Most providers in all the countries except Nepal reportedly provide HIV counselling to married and young males and females. In Bangladesh and Pakistan, more number of service providers reported to have counselled married young women than men were while in India an equal number of service providers reportedly counselled both married young women and men. Provision of HIV testing to young married men and women is low with about 2 out of 10 providers in Bangladesh and India and one out of ten providers in Nepal and Pakistan likely to provide such services.

Overall, service providers in Pakistan and India followed by Bangladesh are likely to provide at least one of the services-either STI counselling or diagnosis and treatment, HIV counselling and or testing. In comparison, the provision of such services in Nepal is rather low.

In the context of HIV & AIDS, perceptions regarding the most vulnerable group among young married male, young married female, young unmarried male and young unmarried female varied across the countries. Providers in Bangladesh and Nepal perceive that young unmarried males are most likely to be vulnerable to HIV, while in India and Pakistan providers perceive young married males to be more at risk than unmarried males. Overall, the providers perceive married and unmarried men/boys to be more vulnerable to HIV than married and unmarried women/girls.

Advice on partner notification

The importance of partner notification in case of RTI/STI/HIV cases is recognised by most service providers across the countries with the exception of Nepal. Advising married male or female clients with RTI/STI/HIV related symptoms about partner notification was reportedly practiced by most service providers covered by the study in Pakistan, while two third in Bangladesh and about half in India reportedly practice the same. In Nepal, only a few mentioned providing information to their married clients.

6.4 Training

Training

There is a felt need among service providers for specific training in imparting information to men on various topics such as safer sex/sex education, HIV, family planning, care during pregnancy, delivery related care, abortion/post abortion care and adolescent reproductive care. In Nepal, most providers mentioned having received training on these issues while the proportion of providers reportedly having received training was lowest in Pakistan. Across the countries the most frequently mentioned training received were on the issue of family planning and care during pregnancy.

The service provider were asked whether they had received training on the following topics: family planning counselling; pregnancy related counselling and services, abortion/post abortion care service; STI/RTI counselling diagnosis and treatment; HIV & AIDS counselling; HIV & AIDS testing; HIV & AIDS treatment; adolescent reproductive health services. The study shows that more service providers in Bangladesh and Pakistan reported to have received training on various issues than in India and Nepal. Most of the providers expressed an interest in receiving training on these topics since they have not had any previous training.

6.5 Provider's attitude towards SRH

Health service provider's perspective on sexual and reproductive health was assessed through their opinion on various topics such as provision of counselling to unmarried adolescents; adolescents' need for counselling and; provision of safe abortion by service providers to unmarried adolescents. Overall, there were mixed responses regarding the effects of access to reproductive and sexual health counselling and services on adolescents.

Contraceptive counselling

Perception and attitude of service providers towards contraceptive counselling was assessed through their response to statements such as: may encourage adolescents to indulge in

sexual behaviour; will promote unwanted pregnancies and; will reduce the risk element of adolescents' sexual behaviour.

Service providers in Bangladesh and Pakistan than those in India are more likely to agree with the statement that contraceptive counselling may encourage adolescents to engage in sexual behaviour while service providers in Nepal are most unlikely to agree with this perception. With the exception of Pakistan, service providers are likely to disagree with the statement that contraceptive counselling will promote unwanted pregnancies among adolescents and in contrary are likely to agree that it will reduce unwanted pregnancies. Majority of the service providers across the countries are likely to perceive that contraceptive counselling will reduce the risk element of adolescent sexual behaviour.

The service provider's attitude towards SRH counselling for adolescents was assessed through some statements made against the need for adolescent counselling such as adolescents are to be disciplined rather than counselled; they should be controlled by their parents/guardians/teachers; that emotional turmoil in adolescents is related to hormonal imbalance and; counselling adolescents will be more expensive since they are the biggest segment of the population.

As emerged from the study, mixed perceptions exists regarding the need for counselling adolescents. The data shows that among the study countries, service providers in Pakistan are more likely to agree with the statement that adolescents are to be "disciplined" rather than counselled. Overall, service providers are likely to agree that adolescents should be controlled by their parents/guardians/teachers rather than be counselled. Service providers in India followed by Pakistan are also most likely to agree that emotional turmoil in adolescents is related to hormonal imbalance. Service providers in Pakistan are more likely to agree to the fact that counselling adolescent will be more expensive since they are the biggest segment of the population.

The situation described above has a direct bearing on young people's sexual rights as outlined in the IPPF's *Exclaim!* document. One of the 'core sexual rights' (number 7), as outlined by the document relates to The Right to Health. The document points out that 'Every young person has the right to enjoy the highest attainable standard of physical and mental health and well-being, including sexual and reproductive health' (2011:23). Quite clearly, if attitudes towards contraceptive counselling in particular and SRH counselling in general include the idea that these are likely to make young people more 'promiscuous', and that in matters of SRH they should be 'disciplined' rather than counselled, then it may create a situation of denial of the right to good health. Indeed, not only the right to health, but the above situation can also be said to contravene another crucial right in the IPPF document, viz., 'the right to know and learn' (2011:24). If we are to ensure that young people's sexual rights are both achieved as well as respected, then it is important to improve the contexts and processes of SRH counselling that relate to them.

Safe abortion services

To assess the attitude towards provision of access to safe abortion services to unmarried adolescents, the service providers were asked to respond to the following statements:

provision of access to abortion services reduces contraceptive usage of adolescents; encourage adolescents to enjoy sex and to receive services later; enables adolescents to recognise that they have a greater control over their body; will respect the choice of adolescents to terminate unwanted pregnancies.

As it emerged from the study, there are varied perceptions regarding the provision of safe abortion services to unmarried adolescents. The data shows that more service providers in Pakistan than in the other countries are likely to link provision of access to safe abortion service to reduced use of contraceptive usage among adolescents. While service providers in Pakistan followed by India are likely to perceive that provision of safe abortion services will have negative outcomes and will encourage adolescents to enjoy sex and to receive services later, providers in Bangladesh and Nepal express more positive attitude and are likely to disagree with the statement. Service providers in Bangladesh and Nepal are more likely to perceive that provision of safe abortion service enables adolescents to have a greater control over their body. Interestingly, service providers across the countries expressed positively that provision of safe abortion services for unmarried adolescents will respect the choice of adolescents to terminate unwanted pregnancies. This aspect is closely linked to 'the right to life and to be free from harm' aspect of sexual rights of young people (*Exclaim!* 2011:19). For, 'The refusal to perform health procedures, such as safe abortions, should never place a young person's health or life at risk' (2011:19).

Conclusion can be drawn that among the study countries, service providers in Pakistan are least likely to positively view the provision of safe abortion services to unmarried adolescents while service providers in Nepal are most likely to have a positive attitude towards the same issue.

CHAPTER 7

RECOMMENDATIONS

This chapter focuses on the broad recommendations and suggestive strategies for the future course of the programme. The recommendations are:

- The findings confirm that men in the study locations, who display more gender equitable norms, are significantly more likely to self-report a range of positive behaviours and attitudes. This provides further evidence that interventions seeking to improve SRH of men and women should explicitly focus on working with men to address issues of gender (in) equity.

- It is imperative that health workers active in the area of SRH be imparted training in both understanding masculine behaviours including anxiety, as well as methods of collecting such information in order to incorporate it into all SRH programmes.

- The inclusion of men as an indispensible part of SRH programmes requires an approach that incorporates not just individuals but also collectivities. Given that there are men who belong to multiple public associations and are likely to accept advice offered at such forums, it is important to identify groups that may be approached to further the aim of increasing men's participation in SRH programmes. Such associations may include village governing bodies, religious associations, and other organisations of common interest to which men belong.

- All SRH programmes, whether addressing men or woman should include a module that explains the importance of focusing on masculinity in a clear and explicit way. The module should contain clear definitions of key concepts as well as case studies that illustrate and explain how such focus leads to better implementation as well as the possibility of achieving desired objectives.

- It is important to develop frameworks for understanding the conditions under which men's attitudes towards gender equality and sexual and reproductive health show the greatest openness. For example, what kinds of men are most likely to accept gender equality and express concern for their as well as their wives' SRH? What is it about their lives that make them so? What anxieties surround hostility to gender equality and SRH ideas? Is it possible to influence the conditions under which men become more receptive to ideas of gender equality?

- Service providers should be provided training to deal with issues that relate to different ways in which masculine identities impinge upon ideas of gender equality and SRH. Training material might include simple question and answer flash cards, case studies, and a list of the most relevant contexts of relationship between masculinity and SRH.

- All SRH training materials should include discussions (or modules) on sexualities, including youth-related issues. Sexuality is a crucial context for understanding gendered behaviour, as well as a site of anxiety, restrictions and violence. Health professionals should be imparted training on how to sensitively address issues of sexuality, while keeping in mind the ways in which attitudes might be constrained by gendered notions of honour, shame and 'appropriate' behaviour.

- Integrated programmes need to change social norms around masculinity that undermine men's and women's health. It is, therefore important to address beliefs that grow out of relationships between cultures of masculinity and, say, contraception. Given the significance of relationship between contraception, gender equality and SRH, the belief that the availability of contraceptives among women may lead to 'promiscuity' must be addressed directly.

- Given that there are significant differences in how women and men perceive the care that men provide to women during pregnancy and child-birth, and given that such care is crucial to SRH of women, specific programmes should be devised to encourage greater participation by men in providing pre and post-natal care through pointing out benefits to both men and women of such activities.

- Lower rates of vasectomy are frequently due to lack of or incorrect information. There appears to be a significant belief that vasectomies reduce male sexual pleasure. The idea of 'pleasure' is strongly related to perceptions of 'rights' of men during sexual intercourse. This aspect needs to be addressed so that SRH benefits of vasectomies are properly reaped. There does not appear to be any deep-seated aversion to vasectomies, and low rate may be because of lack of proper information on a number of aspects relating to it.

- Given that a negligible percentage of men across the region either reported or sought treatment for STI's, this has considerable implications for the health of women. The dominant perception seems to be that a man should seek medical help if his wife has STIs. The refusal by men to accept STIs seriously and access medical assistance must be addressed as a health issue and also from gender equity perspective. The cultures of masculinity that obstruct health seeking behaviour in this instance must be seriously explored and effectively addressed.

- Sexual and reproductive health programme must address the issues of gender based violence as a matter of rights and health. It should engage men and provide them with a clear role in prevention and speaking out against such violence.

- Some of the most common reasons for VAW are linked to masculine ideologies of gender. These include ideas of women's 'moral' behaviour and expectations from men regarding compulsory domestic labour. Responses by several men that VAW is an accepted form of male behaviour are also part of this mix. There are aspects of SRH programmes that should be tailored to address issues of VAW. SRH issues and those of VAW are connected in as much as sexuality is a significant context for VAW and good SRH health.

- There is a need to change the image of health institutions as 'female specific spaces' of health care to one which can be accessed equally by couples and married or unmarried men/boys. Health service delivery needs also need to take into account and be oriented towards the health needs of men/boys.

- Existing family planning services should be re-orientated to provide with a range of SRH services, including a specific package of services that address men's needs. This should include males of all sexual orientations, including those who have sex with other men. The service providers should be trained with appropriate technical skills on male SRH.

- It is important to formulate SRH strategies that take into account the needs of young people as a distinct category. In addition to other factors, the kinds of control and restrictions experienced by young women affect both their health as well as their status as equal citizens.

- Given that a very significant proportion of men seek assistance and advice on SRH issues from 'traditional' healers, it may be worth exploring whether such practitioners can be part of SRH programmes. Perhaps through proper training, this group can become an important resource in addressing the needs of SRH of men. Ignoring this category of service providers or treating it as 'quackery', has not lessened its significance in the lives of men who are the focus of analysis in this report.

- Sexual and reproductive health programmes should support the development and promotion of gender equitable fatherhood, and recognises the important role of fathers in safe motherhood and antenatal care, as well as in the promotion of women and adolescents' physical and psychological well being.

- More research is needed to understand women's perspectives on attempts to work with men on their inequitable attitudes and behaviours and to understand policy makers' priorities and political feasibility of scaling-up a stronger focus on working with men and boys.

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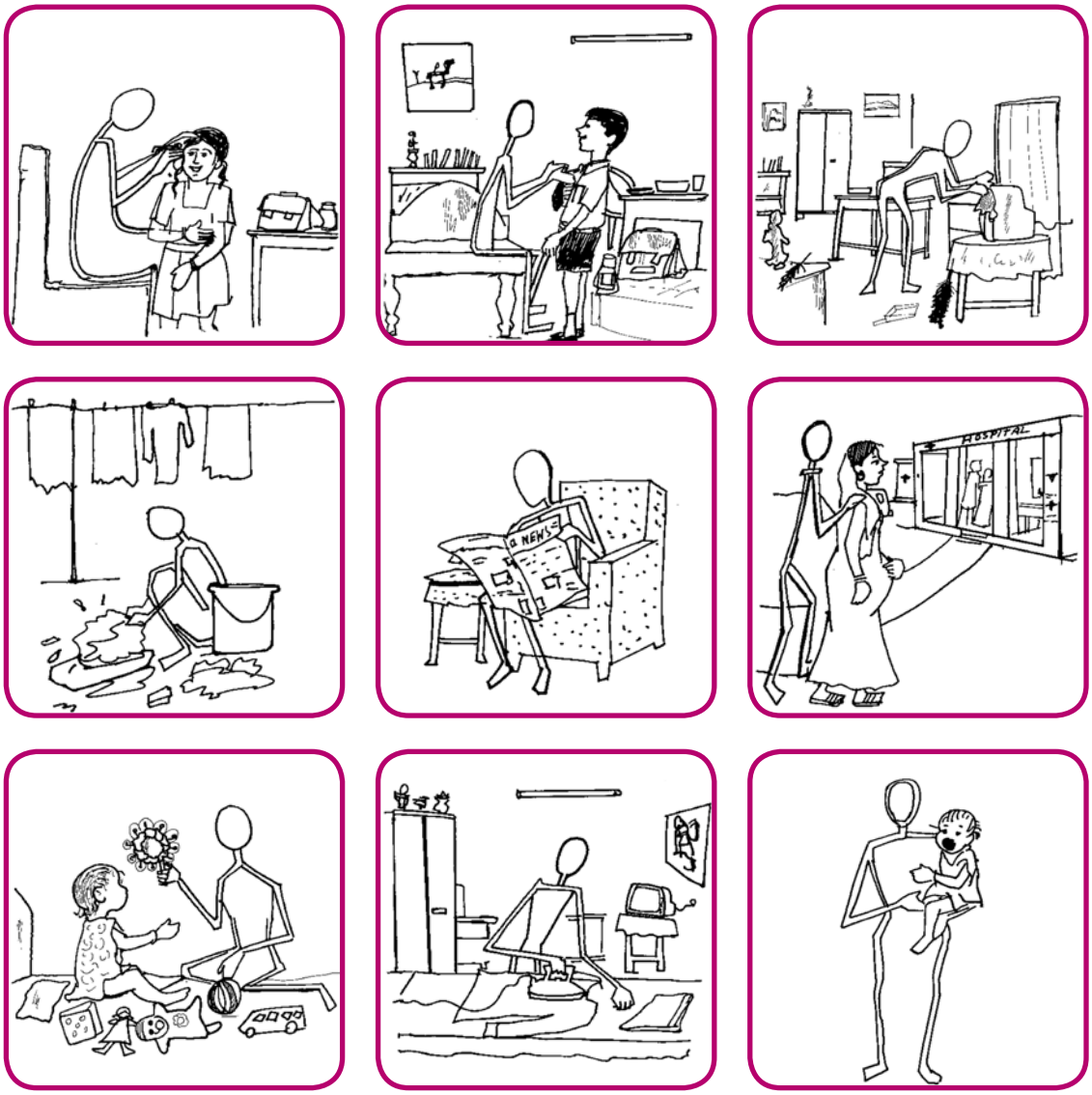
PICTURE CARDS USED IN FOCUS GROUP DISCUSSIONS



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