



ISSUES IN BRIEF

Improving Women's Reproductive Health in India by Educating Men and Families



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In the area of sexual and reproductive health, a global movement has made care delivery for women a major priority. Beginning with the International Conference on Population and Development at Cairo in 1994, the world community focused attention on ensuring that all women are assured of the right to sexual and reproductive health regardless of whether they sought such healthcare as individuals or within the context of a relationship (Germain et al. 2015).

Along with these internationally agreed upon goals, maternal mortality remains as one of the top priorities of the reproductive health program in India (NHP 2015). Five of the 25 nationally sponsored health programs are focused almost exclusively on the sexual and reproductive health of women. In addition, there are state sponsored programs in many regions. Both national and state run programs function primarily through the medium of female change agents or Accredited Social Health Activists, ASHAs (NHP 2015). The reproductive agenda has largely been shaped by the need to safeguard the rights of women as individuals. The public health workforce tasked with achieving these goals comprises mainly female outreach workers and peer counselors.

While prioritization is essential in healthcare provision, such policies run the danger of under-representing the needs of men. In the case of reproductive health, prioritizing one gender over another affects the health of both partners. Reproductive

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health in many instances belongs to a couple; the basic unit in these instances is not comprised of a single gender but of a partnership. While there remains a need to be vigilant that the rights of individual women are not trespassed upon by inequitable systems, gendered interpretations of vulnerability have led to an incomplete description of the complexities involved in healthy reproductive behavior for a majority of Indian women.

This paper explores the need for a more comprehensive understanding of couple and family interactions in planning for reproductive health. It argues that community-based programs that account for couple and family interactions in sexual and reproductive health do not hinder women's empowerment, but contribute to better outcomes for both men and women. Further, it contends that one of the major reasons India continues to demonstrate poor outcomes for women's health, despite having progressive policies for women, is the unwillingness to work with the social structure that exists. There is discomfort acknowledging that the role of traditional social norms and decision-making dynamics don't fit with widely-held perceptions of modern female agency. Yet public health efforts have been found to be most effective when they understand and work with existing social structures to achieve change through education and dialogue (Kumar et al 2015; Daniel et al. 2008).

Expanding the Focus Beyond Independent Care Seeking

Reproductive health programs in India have been guided by a perspective that sees autonomous decision-making by women as one of the most important contributors to health outcomes and lays a large proportion of the blame for adverse outcomes on the patriarchal social structure. This woman-centric approach has ensured that systems are mandated to provide care and cannot deny services. It has, however, failed to account for the process by which women make decisions, mainly in consultation with other family members: more than 23 percent of women make decisions on health care in consultation with a family member and 48 percent have a family member decide for them (Senarath and Gunawardena 2009).

Families typically are in a position to provide women with the support they need to maintain healthy lifestyles. However, the "autonomy frame" often positions men and the marital family as obstacles to care seeking, when they too are equally, if not more, disadvantaged in interactions with the health system. Saha et al. (2007) found in a knowledge-attitude survey among the Khaiwar men (members of a socio-economically vulnerable group in central India) that only 17 percent of participants had heard of HIV-AIDS, only 59 percent had heard of family planning and many lacked accurate information on male sexual health issues. Men are unable to access services when programs for sexual and reproductive health exhibit a predominantly maternal – child orientation (Collumbien and Hawkes 2000). This approach is not only detrimental to men's health but contributes to ill health among female partners as it prevents men from providing the required support (Saha et al. 2007).

Barua (2001) describes a four-step process of decision making for health care seeking by women in Maharashtra. These are described as:

1. "Feeling" a need (where the woman decides she has a symptom that needs care)
2. "Expressing" a need (where she talks to her family about the symptom)
3. "Assessing" the need (where the family decides whether the symptom requires treatment)
4. "Addressing" the need (wherein health care is sought)

The researchers found that this process worked well for general medical ailments, and 97 percent of women had their needs met, in spite of working through this extended system of decision making. This process is likely similar in most parts of the subcontinent due to a common historical and cultural legacy. The decision to seek care is the first step in obtaining health care, and, more importantly, it is the first stage at which seeking care can be delayed (Thaddeus and Maine 1994).

Results from the 2005-06 National Family Health surveys found that the most commonly stated reason for not receiving prenatal care was that the husband or another family member thought it was unnecessary. Husbands were more likely than other family members to be opposed to it, and at the same time, husbands were less likely to have received information from a community health worker on symptoms requiring urgent care. Only 50 percent of men attended a prenatal clinic with their wives, and even fewer knew what to do in case of complication during pregnancy (IIPS 2007). Qualitative studies on maternal mortality in India point towards a general lack of consensus within the family on how soon care is to be accessed and which facility (among the large number of private and public hospitals) provides the best care (Jat et al. 2015).

Whether family members provide support appears to be dependent on them having information, believing that this new information is beneficial, and the ability to agree on how such information might be used (Kumar et al. 2015). Previous research on decision-making offers nuanced narratives, with women describing varying levels of dependence, negotiation, and support. Their involvement in health care seeking is influenced both by social norms and personal sentiment (Rao 2015). A unifying theme is the continued influence of mothers-in-law and the expectation that men, particularly husbands, will provide financial support for medical care and take charge during emergencies. However, under the current system, men who are expected to provide material support are excluded from most conversations with health care providers. Health systems don't provide space for partner involvement and women themselves are hesitant to broach the subject.

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The ASHA and Her Limitations

Within this social environment, the Accredited Social Health Agent (ASHA), who has been assigned community mobilization, hasn't been able to fulfill her role. Her performance as a peer counselor is pitted against both community and household power dynamics. Though seen as a liaison between families and health facilities, she doesn't enjoy strong support from either group. Many ASHAs also do not have a clear understanding of their responsibilities. As a result, ASHA performance has been inconsistent with regard to counseling and mobilization (Sharma Webster and Bhattacharyya 2014). At present, the ASHA functions as a facilitator, accompanying families to health facilities if they require the service (Fathima et al. 2015).

The Need to Align Modern Medical Information with Traditional Beliefs

Development efforts in rural India seek to replace harmful traditional cultural practices with more healthy modern ones. Interpretations of “harmful” culture vary from merited criticisms of specific dangerous local traditions to more complex, less rational, criticisms of family and community dynamics. It is a constrained view that interprets culture as more directly contributing to ill health than all other spheres of health-related activity. It is also unlikely that there is only a single healthy culture and that every human society will fit that mold. It is important to draw the distinction in women’s health between oppressive mechanisms and supportive mechanisms. For this, further research in the area of reproductive health decision making is necessary.

Kumar et al. (2015) describe the need to understand the rationale and process of community behavior before designing health interventions. They illustrate that programs can only succeed when they align the aspirations of a public health cadre schooled in a scientific tradition of inquiry with traditional mores of communities. They stress the importance of stepping aside from ethical judgments of right and wrong as both policymakers and

communities are interested in the same goal of a healthy life. The real difference lies in the interpretation of what constitutes healthy behavior. Kumar et al. (2015) studied the conflicting views surrounding neonatal deaths in Shivgarh, Uttar Pradesh. The problem, they discovered, was a belief among families that birth was by nature an unclean process. This led to a reluctance in adopting hygienic precautions during delivery. These precautions were considered superfluous and the concept of infection was not clearly understood. This discovery led the authors to work to align existing shared beliefs with evidence-based practice and focus

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on integration with, rather than disruption of, tradition. The process involved the use of cultural metaphors to promote modern behavior and an exploration of how medical concepts could be communicated as analogy. The key concept that emerged from this project was the importance of understanding norms and working *with* or *around* rather than *against* those norms. The authors describe this as “enculturating science.” The project succeeded in halving the number of neonatal deaths in Shivgarh within 16 months between 2003 and 2005 (Kumar et al. 2008).

The ideological hurdle with neonatal deaths was the perceived inferiority of traditional thought and the absence of attempts to communicate scientific concepts in cultural terms. An analogous thought process characterizes women’s health movements. Here the need to empower women to decide independently gains predominance over any alternative mode of improving access to and use of health care services. This has resulted in an overtly aggressive criticism of family formation and male authority. In order to succeed, women’s reproductive programs in India need to move away from the rhetoric of radical feminism toward the reality of working within a patriarchal structure. Seeking to dismantle existing gender norms while designing reproductive health programs has not changed the method by which women make decisions, but has excluded important participants from the dialogue.

Targeting men or couples in addressing women’s reproductive health is not intended to alienate single women and those who choose to access services independently. Rather it is aimed at another segment of the population, the vast majority of Indian women, whose way of life involves family-based decision making.

From Autonomy to Interpersonal Communication and Equitable Involvement — the Argument for Educating Men

Mumtaz and Salway (2007) argue that policies for women in South Asia need to move away from the autonomy-empowerment paradigm alone and focus on family, society, and community relationships. Most literature overwhelmingly argues for increasing the involvement of men. Research studies from the subcontinent repeatedly document the need to aim reproductive health messages at both partners in a couple (Saha et al. 2007; Chattopadhyay 2012).

Programs that involve both partners have demonstrated good results. The Krishi Gram Vikas Kendra (Jharkhand), a local non-governmental organization, co-ordinated a quasi-experimental trial, between 2004 and 2007, designed to train providers on the realities of gender-based power dynamics and to involve men in family planning services. The intervention categorically did not address women’s empowerment alone and chose to focus on couple centric decision-making. Men were involved through the Information-Education-Communication (IEC) protocol within intervention areas. The researchers concluded that addressing the concerns of both partners not only met the need for contraception but also improved participation in decision-making by women (León et al. 2014).

The Promoting Change in Reproductive Behavior (PRACHAR) project in Bihar demonstrated that when families were included in discussions, it helped improve family planning outcomes. Between 2002 and 2004, the project conducted meetings with couples and their parents to encourage birth spacing and delayed age at first pregnancy. Meetings were held both in homes and at the community level, separately with both men and women. The program focused on “gender egalitarian sexual decision making.” This program also targeted parents of young adults through their community level messages and home meetings with mothers-in-law. As a result, odds of contraceptive use were 3.8 times greater within intervention communities when compared to control communities (Daniel et al. 2008).

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In a nutshell, programs that have worked to change behavior in India have facilitated conversations within families. In the translation of policy to action, the ASHA needs to be equipped with innovative tools to fulfill her role as an activist. Methods that seem promising are those that encourage and promote the sharing of ideas. Ramachandran et al. (2010) found that providing ASHAs with skills to create mobile videos provided them a means of engaging all family members in the dialogue. This also was effective as a means of encouraging both ASHAs and families to appreciate the value of home visits through “participation and play.”

The real shift in strategy therefore needs to be from empowering women alone to empowering families. The challenge is targeting both partners in a couple simultaneously. The PRACHAR project which focused on family planning achieved this through discussions and workshops with groups of married men, married women and adolescents. Determining the ideal time to influence couples on adequate prenatal and postnatal care during the reproductive period is an area that needs further research.

Conclusion

In India, health systems are legally structured to provide confidential services to women. However, due to the silence surrounding sexuality and the inaccessibility of health systems, women often are unable to access the care they need. A majority of women are also likely to rely on their families to support or make the decision about their care, in all matters that affect reproduction and fertility (Senarath and Gunawardena 2009; Ruducha et al. 2014). Under such circumstances, the rational step for any public health program is to educate the members of the family who participate in the decision making process.

Of course, it is necessary to ensure that women are in a position to take advantage of available services independently and confidentially if they so choose. Improving female literacy is an area that shows consistent association with increased empowerment (Gupta and Yesudian 2006). Programs might therefore also focus on keeping girls in school, regardless of age at marriage, and helping married adolescents re-enroll in school.

Most importantly, we need to move away from a paradigm that places the blame for poor reproductive outcomes solely on a social structure, especially in an environment where unregulated private sector pricing and poor public sector infrastructure contribute equally if not excessively to the problem. Characterizing women's poor health outcomes as a failing of patriarchy has limited validity. It is important for policy makers and other non-governmental organizations to consider the potential of including male partners while designing future reproductive health programs for women in India. ●

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