Review Article

Indian Journal of Research in Anthropology
Volume 2 Number 1, January - June 2016

Approaches of Involvement of Male in Reproductive Health: Changing Paradigms in Anthropological Research

Jitendra Kumar Premi*, Mitashree Mitra**

Author Affiliation: * Seniour Assistant Professor ** Professor, School of Studies in Anthropology, Pt. Ravishankar Shukla University, Raipur, Chhattisgarh, India-492010.

Reprint Request: Jitendra Kumar Premi, Seniour Assistant Professor, School of Studies in Anthropology, Pt. Ravishankar Shukla University, Raipur, Chhattisgarh, India-492010.
E-mail: jitendra_rsu@yahoo.co.in

Abstract

All culture have involved some system of explanation regarding conception, pregnancy, and childbirth and all have developed sets of beliefs and techniques for dealing with these mammalian and human processes. All societies have been able to connect the act of sexual intercourse to the onset of pregnancy, its outcomes and their survivals. Various cultures of the world, primitive as well as civilized, are sufficiently acquainted with the fact of biology to relate the pregnancy of a given women to the act of sexual intercourse. Culture influences not only how individuals are treated for their reproductive health problems within given systems of medicine, but also how individuals living within local communities define and experience their reproductive health. Reproductive health has emerged as an organizational framework that incorporates men into maternal and child health programs. For several decades, medical anthropologists have conducted reproductive health research that explores male partners' effects on women's health and the health of children summarizes exemplary research in this area, showing how ethnographic studies by medical anthropologists contribute new insights to the growing public health and demographic literature on men and reproductive health. The contributions of cultural anthropology, with its ethnographic tradition of in-depth, field based research and its central concept of culture. Cultural anthropologists have argued that gender is a key organizing principle of social relations, influencing both sex and reproduction. In this paper it is try to understand the wholistic characteristics and dimensions of the research in the reproductive health and involvement of men.

Keywords: Anthropological Approaches; Appraisal; Involvement of Male; Reproductive Health; Participation of Men.

Introduction

It is well recognized that in patriarchal settings such as India, hierarchical gender relations and unequal gender norms impact women's sexual and reproductive health and choice and act as significant obstacles to access of services and facilities. Equally, the achievement of good sexual and reproductive health may be inhibited by such structural factors as poverty and malnutrition, early marriage and inadequate educational and health systems. Although there are regional variations with women in the non tribal facing some what fewer constraints than those in the tribal, undoubtedly women in both regions are far less empowered to have a say in their own lives than are men. From an early age, gender role differentials persist: compared to adolescent boys, females have limited autonomy and face huge constraints on decision making, mobility and access to resources. Double standards ensure that young females are closely supervised as theirs. Chastity is inextricably linked to the family's honour (both natal and marital). At the same time, daughters are viewed as a 'source of misery' and a drain, through dowry, on the family's resources, while a son is 'the saviour of the family.' After marriage, a young woman is expected to remain largely invisible and under the authority of her husband's family. She has little say in domestic decisions and little freedom of movement.

Almost the only avenue available to enhance her prestige and even security in her husband's home is through her fertility, and particularly the number of sons she bears. Women who have borne only daughters can be subjected to harassment, and childlessness can be grounds for divorce or abandonment. Gender roles have significant implications for sexual and reproductive health and choice. Gender norms condone early onset of sexual activity, pre- and extra-marital casual sexual relations. Lack of awareness, lack of spousal intimacy and communication on sexual matters, and widespread gender based violence compound women's inability to negotiate safe sex, seek appropriate health care or experience a healthy pregnancy. Finally, gender roles that perpetuate the 'culture of silence' inhibit women from communicating a health problem or seeking prompt treatment unless it inhibits them from carrying out their daily chores. This 'culture of silence' is even more exaggerated for gynecological and reproductive morbidity that are so closely linked with sexuality.

Reason why WHO [94] recommended that there is a need to improve men's knowledge, access to and use of effective reproductive health care services. Programmes should be designed to raise awareness of men about risk, benefits of protection and the consequences of delayed and inadequate treatment of STIs. Programme managers should attempt to plan and implement a variety of interventions to involve men and monitor the impacts of these interventions. Research findings should be incorporated into programme planning. Couple counselling sessions may not be the ideal situation for the discussion of STI risk. With respect to the control of genital discharge syndromes, syndromic management for symptomatic men is more effective than for women in some epidemiological settings. Epidemiological evidence suggests that the effectiveness of STI control is likely to be greater if programmes focus on identifying infected men, as well as women. The contributions of cultural anthropology, with its ethnographic tradition of in-depth, field based research and its central concept of culture. Cultural anthropologists have argued that gender is a key organizing principle of social relations, influencing both sex and reproduction. Recent cultural anthropological research on men and masculinity, much of which falls outside of current conceptualizations of men's reproductive health, but which nonetheless forms part of the matrix of relations influencing men's as well as women's reproductive well-being [19]. At this juncture it has mentioned some of important issue which has proved to necessity of the present study.

Reproductive Health: An Anthropological View

All culture have involved some system of explanation regarding conception, pregnancy, and childbirth and all have developed sets of beliefs and techniques for dealing with these mammalian and human processes. Thus, all culture has a gynecology, embryology and obstetrics, and insofar as well as use system of child care and treatment, pediatrics [13, 25, 58, 80, 8, 34, 63]. Each of these arts and science is predicated upon statuses and roles of mother, father, child and those members of their social networks most intimately related to them. Gynecological, embryological, obstetrical, and pediatric values, tradition and practices framed within a cosmology and world-view of a people and their place in the universe, and within a particular type of social system. All societies have been able to connect the act of sexual intercourse to the onset of pregnancy, the two possible exceptions being among some Australian aborigines and the famous Trobiand Islanders of Melanesia who were thoroughly investigated by Malinowski [51]. In these two areas the fact of paternity is reportedly unknown and conception is assumed to take place through impregnation of the mother by "baby spirit" [53].

Although as a myth this belief is held in many parts of the world including the folk societies of the West [80]. Elvin [20] explored the sexual behaviour pattern of Baiga and reported that sexual intercourse between a men and women is necessary for the birth of a child, that is the normal rule, the Baiga would not, however, go so far as to say that a virgin cannot conceive, it just possible that she might become pregnant by drinking urine, in the folk-tales one girl drinks a cup of jackal's urine and has a litter of jackal's cubs. Elwin [20] also reported that Baiga embryology diagnosis, the beginning of pregnancy by the stopping of the menstrual period for two months, and by the swelling of the breast, if the nipples grow black, it is believed that a boy will be born, if they turn brown, it will be a girl.

Various cultures of the world, primitive as well as civilized, are sufficiently acquainted with the fact of biology to relate the pregnancy of a given women to the act of sexual intercourse. It is of course true that native lore regarding the physiological processes of gestation is highly variable from area to area in the world. Some primitive groups, while they recognize that coitus is the normal cause of pregnancy, entertain the notion that women may conceive in other ways. The South African Hottentot, for example, have a myth telling of women who became pregnant by eating a certain kind of grass. The mythology of the Bontoc Igorot of the Philippine Island is so ridden

with magical tales that magical conceptions are not regarded as improbable. If the menstrual discharge is washed downstream it may be used by spirit to create heroes of great power. In myths, the frog motif is popular; the frog, lapping up the spittle of a hero, is impregnated and gives birth to an attractive and talented child [81].

Culture influences not only how individuals are treated for their reproductive health problems within given systems of medicine, but also how individuals living within local communities define and experience their reproductive health. One area of particular interest involves the cultural determinants of reproductive health. It is clear that culture, as a predominant system of beliefs and practices shared by a group, affect reproductive health outcomes. Discussion of culture in reproductive health initiatives to date has tended to focus on the beliefs and practices concerning the origin and treatment of reproductive health problems, particularly as they present barriers to biomedical intervention [19].

Cultural anthropologists, too, have emphasized the importance of social relation such as division of labor, social status, and household's arrangements, in determining the nature of family life and child well-being. In particular, the cultural and personality school of anthropology has emphasized the effects of early childhoods experience with parents, as determined in part by these social structures, in determining adult behavior. Such a perspective focuses on the way culture reproduces itself, suggesting that parenting behavior is in part determined by cultural norms and values, which are then impressed upon children at early ages in ways that will affect their adult lives while the culture and personality perspective has been challenged as overly deterministic, the perspective has made valuable contributions in understanding cross-cultural patterns of fathering, such as the effects of father absence on offspring, ceremonies of male initiation, and male segregation at puberty[86].

Ethnographic account offering descriptions of the majority of the cultures of the world are not generally helpful in explaining the ways in which the various primitive groups determine when conception occurs and pregnancy begins. As nearly as can be ascertained, cessation of the menses is symptomatic of pregnancy in the belief and according to the observation of nearly every society. To choose an example from Africa: the Loma and Gbunde of Liberia take the view that conception may follow immediately upon menstruation may. There after the disruption of menstrual regularity is regarded as proof of pregnancy. But some other societies utilize other symptoms as indication. Various scattered groups over the world look for changes in the breast as well as cessation of the menses. Morning sickness is considered as evidence of pregnancy by some primitive groups [81].

Batchelder [4] described the anthropologists have found that in reality, modern societies have simply made the process of physical abuse and offspring selection more subtle, masking it with technology in simpler societies children are subject to traumatic, mechanical and violent health threats that we consider primitive and severe. However, in modern industrial societies children are subject to more subtle, cognitive and metabolic abuses that are just as damaging to health. According to anthropological studies many of the ongoing physical and emotional problems associated with menstruation in modern, industrial societies appear to be largely a product of urban-industrial lifestyles. Mead [57] found that it was unusual for a young woman in Samoa to complain of menstrual problems. Shostak [79] found that the South African people, the Kung, did not experience PMS or menstrual syndrome and noticed no mood changes around this time of month. Howell[35] also found that menstruation was rare among the !Kung San, Harrell[32] suggests that regular menstrual periods may well be unusual urban-industrial societal effects that reflect low birthrates and short or absent interludes of nursing babies associated with the use of baby bottles.

Mead [56] extensively illustrated about human reproduction, she described if we return then to the small boy and the small girl living in a world where the bodies of males and females of all ages are slightly clothed and simply accepted, we find that the small girl learns that she is a female and that if she simply waits, she will someday be a mother. She [56] concluded that in such a society women are handicapped by their womanly qualities. Pregnancy and nursing are hated and avoided if possible, and men detest their wives for being pregnant. Men see women as a kind of human beings over whom they will have to right and through whom they can be injured.

Reproductive Health and "Men": An Anthropological View

Reproductive health has emerged as an organizational framework that incorporates men into maternal and child health (MCH) programs. For several decades, medical anthropologists have conducted reproductive health research that explores male partners' effects on women's health and the health of children summarizes exemplary research in this area, showing how ethnographic

studies by medical anthropologists contribute new insights to the growing public health and demographic literature on men and reproductive health. Dudgeon and Inhorn [18] explored reproductive rights, examining the concept from an anthropological perspective. Reproductive health policymakers (and their critics) have recognized the need for qualitative research to improve understanding of male involvement in reproductive health, as well as men's reproductive health problems [17, 54, 71]. Because of its long tradition of research among non-western populations, as well as its qualitative research strategy of ethnography, the discipline of anthropology has been seen by many as a means to investigate local reproductive norms and problems, as well as to implement a gendered perspective that does not assume universal meanings of masculine and feminine. Anthropology has, to date, been characterizes as a discipline suited to complement biomedical health interventions with qualitative knowledge that will improve the deployment of those interventions [19].

Anthropology is rapidly growing in this complementary role to international health efforts [77, 87]. Nonetheless anthropology has more to offer than local knowledge in the area of reproductive health. For one, medical anthropologists have often taken a critical stance toward international health efforts, [48, 52, 60] including men's incorporation in reproductive health interventions [9]. From this critical medical anthropological perspective, culture influences the very character of biomedicine, both as a western discipline and as a form of health care now found in many non –western sites around the globe [40].

Dudgeon and Inhorn [19] explored how anthropology, as a humanistic social science, is particularly well suited for assessing men's reproductive health needs, through its emphasis on both the specificity and variability of those needs within local cultural contexts. Relying on a biosocial perspective, anthropologists who focus their research on reproduction generally argue that local biologist, as well as local cultures, influence men's reproductive health definitions and needs. Understanding men's reproductive health needs requires framing men's health and well-being within local contexts the traditional focus of anthropology.

One of the more important shifts emerging since the Cairo and Beijing conferences has been the explicit adoption of the concept of gender as an important determinant of reproductive health. Borrowed from linguistics and deriving from work in feminist theory and humanistic social sciences such as anthropology, the concept of gender was originally used to describe of behavior and identity usually ascribed to either men or women; such attributes could not be determined by biological sex, and thus were referred to as gender roles and identities [45]. However, the concept of gender has been extended by some theorists to describe a set of power relationships loosely organized around biological has been used to account for the different kinds of illnesses experienced by men and women, which are often attributable to power differentials [77]. Ironically perhaps, this "gender lens" has only recently been focused on men even though men have long been at the center of social scientific investigation and health research, often to the exclusion of women [39, 73]. Only recently have men as men-that is, as gendered agents, with beliefs, behaviors, and characteristics associated with but not dependent upon biological sex – become subjects of theory and empirical investigation within the social sciences, [10-11, 78] including in anthropology [5, 30, 50]. While no single framework for the study of men holds, attempts have been made to explain general patterns in male identity and behavior.

Researches in many fields such as medical anthropology and medical sociology have begun to draw connections between gender and men's health [6, 16, 49, 59, 76, 95]. In general, such approaches argue that numerous aspects of health, ranging from accidental deaths to cardiovascular disease is conditioned not only by differences between male and female physiologies, but also by the culturally specific socially constructed gender roles and identities that men and women perform. Courtenay [12] has argued that there is a reciprocal relationship between masculinity and health, stressing that men's health problems are often produced by men's enactment of masculinity, and that cultural norms and expectation reinforce these enactments. In addition, some researchers have observed that certain aspects of health and illness helps define hegemonic masculinity [76]. For example, certain markers of health are emphasized over others (e.g., men's muscle mass), markers that may not fit biomedical models for good health [47]. Moreover, illness in general may be characterized as unmasculine, and some disorders, such as infertility and erectile dysfunction, are seen as particularly emasculating [37, 38, 89]. In some cases, men's health disorders, such as benign prostatic hypertrophy (BPH), can be characterized as "culture-bound syndromes," given differential (and often profitable) emphasis in diagnosis and treatment by doctors and pharmaceutical manufactures. Not surprisingly, many of the aspects of health most closely tied to

masculinity involve reproduction and sexuality. Masculinity affects reproductive and sexual health insofar as sexual behaviors play key roles in defining gender role and identities [14]. Gender approaches stress the culturally constructed meanings of sexual practices in the main demonstrating that other- or same-sex sexual behaviors are not isomorphic with universal definitions of hetero or homosexual, straight or gay identities [33, 50]. In addition, attention has been drawn to the importance of particular sexual behaviors- many of them unhealthful for men and women; for performance of masculinity. Often listed among such practices is sexual promiscuity [23] and avoidance of contraceptives[88]. Such behaviors are theorized as being in a dialectical relationship with masculinity, with the behaviors both contained by and part of the basis for masculine identities and roles.

Defining Reproductive Health

World Health Organization [91] defines "reproductive health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". Reproductive health addresses the reproductive processes, functions and system at all stages of life. Reproductive health, therefore implies that people are able to have a responsible, satisfying and safe sexual life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed of and to have access to safe, effective affordable and acceptable methods of fertility regulation of their choice and the right of access to appropriate health care services.

For both women and men, reproductive health reflects the impact of health in infancy and childhood as well as in adult life, and beyond reproductive age as well as within it. Reproductive health sets the found for human sexuality regardless of whether it leads to reproduction. Because of the HIV/AIDS pandemic, which has demonstrated the implications of sexuality for health and for social and development maters, human sexuality is now high on the agendas of many national and international agencies and organizations [93].

ICPD Programme of Action [41] not only endorsed this view of reproductive health but also helped operationalize what reproductive health care services should include, as follows: "Reproductive health care in the context of primary health care should, inter alia, include: family-planning counseling, information, education, communication and services; education and services for prenatal care, safe delivery and post-natal care, especially breast-feeding and infant and women's health care; prevention and appropriate treatment of infertility; including prevention of abortion and the management of the consequences of abortion; treatment of reproductive tract infections; sexually transmitted disease and other reproductive health conditions; and information education and counseling, as appropriate, on human sexuality, reproductive health and responsible parenthood"[93]. Gender differentials in regard to poor reproductive health stem, in part, from biological factors. For example, women alone face the health hazards associated with pregnancy and childbirth; women with STDs may have no symptoms and, are more likely than men to experience serious complication, such as infections and infertility; and women appear to be more susceptible than men to infection by the AIDS virus because their physiology is more vulnerable to sexual transmission. Furthermore, women experience the health hazards associated with abortion or the inconveniences associated with menopause and increased morbidity.

Other gender differentials stem from social economic and cultural factors. Women's lack of autonomy in sexual relationship can lead to early and excessive child-bearing as well as exposure to STDs and violence. Women who lack decision-making power and control of money within the family often cut off from essential health services, such as emergency obstetric care. Cultural practices, such as female genital mutilation, may lead to life-long disability. Although the burden of ill-health associated with reproduction affects women to a much larger extent than it does men, and few of the reproductive health problems that men face are life-threatening, these problems do affect men's quality of life and may have serious repercussions on women's health. In women, STDs, for example, often lead to infertility and cervical cancer. Some reproductive health problems, such as urological disorder, affect women and men. In women, genital-urinary disorders may remain non-symptomatic and undiagnosed for a long time. In men, these disorders tend to be associated with early signs, which lead to diagnosis and treatment. Other disorders, such as prostate and testicular cancer, affect men solely. Finally, problems like sexual dysfunction have deep psychological effects and may cause males to seek medical treatment and/or counseling.

Defining Male Involvement

"Male involvement" is used as an umbrella term

to encompass the various ways in which men relate to reproductive health problems and programmes, reproductive rights and reproductive behavior. Male involvement in reproductive health has two major facets : The way men accept and indicate support to their partners' needs, choices and rights in reproductive health and men's own reproductive and sexual behaviour.

Other terms that are often used in this context are male responsibility and participation. The terms "responsibility" stresses the need for men to assume responsibility for the consequences of their sexual and reproductive behaviour, such as caring for their offspring, using contraception to take the burden off their partner and practicing safer sexual behaviours to protect themselves, their partners and their families from STDs, including HIV.

The terms "participation" may seem self-evident since men de facto participate more than women in population and reproductive health programmes, as policy makers, media gatekeepers, religious leaders, managers and service providers, community leaders and heads of households. In this context, "participation" refers to men's supportive role in their families, communities and work-place to promote gender equity, girls' education, women's empowerment and the sharing of household chores and child-rearing. "Participation" also suggests a more active role for men in both decision-making and behaviours, such as sharing reproductive decision-making with their partners, supporting their partner's choices and using contraception and/or periodic abstinence. "Changes in both men's and women's knowledge, attitudes and behaviour are necessary conditions for achieving the harmonious partnership of men and women. Men play a key role in bringing about gender equality since, in most societies; men exercise preponderant power in nearly every sphere of life. It is essential to improve communication between men and women on issues of sexuality and reproductive health, and the understanding of their joint responsibilities, so that men and women are equal partners in public and private life" [93].

Reproductive Health and Men

In the public health sector, family planning services have long been offered mostly through the existing outlets of maternal and child health centers, which only women and mothers attend. Partly for this reason, population, development and health agencies have largely ignored men's influence on women's reproductive decisions and actions and the reproductive health need of men. At present, decision makers are examining programmes to involve men in reproductive health decision, including family planning, for several reasons: programmes have found that an acquired immunodeficiency syndrome (AIDS) pandemic and the spiraling rates of sexually transmitted diseases (STDs) have given safer sexual practices and the condom renewed important. Male involvement programmes are designed to address specific problems or impediments, such as men's disapproval of their partner' use of contraception; rising rates of STD/HIV infection and out-of-wedlock pregnancy; restrictions on condom advertising, promotion and distribution; and underutilization of vasectomy services. Still, a gap remains between the rhetoric promoting male involvement and the reality of female-oriented reproductive health programmes. The reasons are several. The major barriers to expanded male-involvement programmes are as follows:

Socio-Cultural Concern

In male-dominated socio-cultural environments, men may fear losing control if they share decision-making and discuss reproductive goals with their spouses. Community norms may promote large families. In difficult economic circumstances, men may look to their children for old-age-support. Other special socio-economic circumstances, such as the separation of migrant workers from their families, present higher risks for men of contracting STDs and human immunodeficiency virus (HIV).

Lack of Political Dedication

Many high-level decision makers have yet to take the necessary steps to institute male involvement in existing programmes. Merely taking and interest in this possibility can cause changes in staff attitudes and practices;

Insufficient Information

The lack of up-to-date information on male attitudes, knowledge and practices related to reproductive health impedes programme planning. Few male-involvement programmes have been evaluated.

Policy Impediment

Outdated policies and regulations hinder male access to contraception. These include the following: high import duties on condoms: restrictions on condom sales and advertising, including sales to the under-aged or unmarried; and strict eligibility

criteria for obtaining vasectomies. Policies in the work-place may discourage men from sharing household chores and child-rearing.

Provider Bias

Men are more concerned about their partners/ spouses and children than the stereotypes would suggest. However, stereotypes are hard to change. The assumption of many health-care providers that men are uninterested in taking responsibility for family planning has become a self-fulfilling prophecy. Most reproductive health/family planning service delivery systems are almost entirely oriented to women and provide little or no information about male contraceptive methods. Health workers are sometimes poorly trained in counseling men about safer sexual practices and male methods and may communicate negative rumors about them. Recent field experience has shown that well-targeted, focused male-involvement programmes can have an impact on both male and female behaviors related to reproductive health. Such behaviors include more responsible sexual behavior, increased contraceptive use and grater communication between partners. These behaviors reflect the major goals of male-involvement programmes, which are to: Provide support for women's actions related to reproduction and respect for women's reproductive and sexual rights, improve male and female reproductive health and encourage safer and responsible sexual and reproductive behavior in adolescents and young men (adolescents : up to 19 years old; young men : 20-24). Recent studies and programme experiences are also challenging many of the traditional assumptions about male-involvement activities, including the following:

Feasibility

Programme mangers assume that men are more difficult to reach than women. In reality, men can be approached in many non-clinical setting. Moreover, men pay attention to the mass media and are generally more literate than women;

Conflict

Despite, complex motivational resistances to changes in men's reproductive attitudes and behavior, studies have revealed that men are more favorable to family planning than popular wisdom assumed and are interested in learning more about contraception and in sharing responsibility for contraception with their partners. Most men want the same number of children as their partners do; male reproductive health services are best provided as a constellation or package of various services or an array of interventions, preferably at or near the same site. Services can be provided in a variety of settings, including Primary Health Care facilities, maternal and child health/family planning clinics, male-only clinics, and clinics for treatment of STDs, mobile units, and military hospitals. Other major sources of services and information are subsidized commercial sales, community outreach, employment-based programmes, youth programmes and organized group.

Traditionally, health care providers and researchers in the field of reproductive health have focused almost exclusively on women when planning programmes and services, especially with regard to family planning, prevention of unwanted pregnancy and of unsafe abortion, and promotion of safe motherhood. In recent years, efforts have been made in many countries to broaden men's responsibility for their own reproductive health as well as that of their partners. Measures are also being taken to improve gender relations by promoting men's understanding of their familial and social roles in family planning and sexual and reproductive health issues.

International Conference on Population and Development (ICPD) Programme of Action,[41] urged that:

"….special effort should be made to emphasize men's shared responsibility and promote their active involvement in responsible parenthood, sexual and reproductive behaviour including family planning; prenatal, maternal child health prevention of sexually transmitted disease, including HIV; prevention of unwanted and high-risk pregnancies; shared control and contribution to family income, children's education, health and nutrition; recognition and promotion of the equal value of children of both sex. Male responsibilities in family life must be included in the education of children from the earliest ages. Special emphasis should be placed on the prevention of violence against women and children…"

The above challenge calls for more intense efforts of foster partnerships between men and women which help men identify with the magnitude and range of reproductive illnesses which affect women. The philosophy embodied in the Programme of Action combines a primary health care approach with a human rights dimension.

Research has shed some light on the gaps in our

knowledge of reproductive health issues as they relate to men, but we have little information about programme issues and how such research could improve programme operation ad service delivery. WHO Country Offices are often consulted by programme managers and policy-makers for advice on strategies for including men in the delivery of reproductive health services.

Reproductive health practitioner have recognized that the failure to target men in programmes has weakened the impact of reproductive health programmes since men can significantly influence their partners' reproductive health decision-making and use of health resources [55].

Moreover, studies have shown that men who are educated about reproductive health issues are demonstrate greater responsibility for their children [29]. Most importantly, women express great interest in wanting their partners to be involved in joint reproductive health decision-making. For example, a study in Ecuador surprisingly showed that 89% of women wanted their partner to accompany them on their next family planning visit and 94% would have liked their partner to be present during their family planning session [75].

Although 1994 was a watershed year for male involvement, Engender Health had already been working with male clients for 50 years on the issue of vasectomy, and the Cairo mandate provided an important framework for considering men's constructive involvement in reproductive health from a more holistic perspective. With this framework in mind, Engender Health initiated a formal Man as Partners programme in 1996 in response to client, provider and institutional request, which became even more frequent and urgent with the onset of the AIDS epidemic.

Gender and Reproduction

Men have a stake in reproductive health through their multiple roles as sexual partners, husbands, fathers, family and household members, community leaders and gatekeepers to health information and services. To be effective, reproductive health programmes need to address men's behaviour in these various roles.

The first reason to involve men in reproductive health stems from the need to promote observance of human rights and the need to enforce equity, i.e., an obligation from the gender and reproductive rights perspective. Men are partners in reproduction and sexuality and, therefore, it is logical that they equally share satisfying sexual lives and the burdens of preventing disease and health complications.

Another reason to involve men in reproductive health matters is that they are responsible, socially and economically, at least in part, for their children. It is hoped that involving men in reproductive decisions will forge a stronger bond between them and their offspring and results in greater responsibility for their families' well-being.

Male Reproductive Health Needs in Information and Services

Men need information, counseling and services to address a wide range of problems and concerns related to reproductive health. Many men are poorly informed regarding sexuality and reproduction and need information about male and female anatomy, contraception, STD and AIDS prevention and women's health care needs during pregnancy and childbirth. They also need confidence and guidance on how to share decisions and negotiate choices with their partners. Clinical services are needed to address common problems, such as uro-genital infections, STDs and infertility and to provide voluntary male sterilization. Depending upon the availability of treatment facilities screening for prostate and testicular cancer may be appropriate.

Knowledge of Family Planning

Most men have heard of modern contraceptive methods. In 11 out of 15 countries (DHS) with recent national surveys, more than three in for married men recognized at least one modern method. Surprisingly, in most of these countries a larger proportion of men than women had heard of a method. The pill was the most-recognized method, followed by the condom and female sterilization. Except in Bangladesh, Rwanda and Kenya, most men had not heard of vasectomy [22].

Use of Male Contraceptive Method

Approximately one third of the women surveyed in developing countries report that they are using a contraceptive method involving male participation or cooperation. In addition, a number of men have been motivated to undergo voluntary sterilization, a permanent method. Others are motivated to use temporary contraceptive methods. About 5 % of married couples in the developing world rely on vasectomy for pregnancy prevention [28] and an equivalent proportion relies on condoms. Usages of these two methods are highest in Asia and generally low in other regions. Periodic abstinence and

withdrawal are not widely used in most developing countries, although there are some notable exceptions [92] For example, withdrawal is the most popular methods of fertility regulation in Turkey, reported by 26 per cent of currently married women [93] in 12 out of 18 developing countries with comparable data the use of contraceptive methods requiring male participation has increased over the past decade. Condoms, which protect against both unwanted pregnancy and STDs, can be made widely available in various non clinical settings. Nevertheless, health providers can play an important role in educating men on their protective role and correct use. Health agencies need to give special attention to young men, since they have a tendency to adopt risk-taking behaviours (such as unprotected intercourse, multiple partners and alcohol and drug use) and are often the prime instigators of early child-bearing. In many areas health services largely ignore the problems of adolescents, since they are generally in good health and do not fit neatly under either pediatrics or adult medicine.

Involvement of Men to Increase Contraceptive Prevalence

Approximately one third of the world's couples are using a male-dependent contraceptive method – condom, vasectomy, withdrawal or periodic abstinence or traditional family planning methods [28] yet, most family planning agencies devote only a small portion of their budgets to male services and outreach. In most developing countries, men are man or untapped market for family planning programmes [31]. Family planning programmes have focused primarily on women because of their direct involvement in child-bearing and the predominance of effective female methods. However, in cultures where men dominate reproductive decision-making, as in sub-Saharan Africa and some Muslim cultures, the exclusion of men from reproductive health, including family planning and sexual health activities may contribute to low levels of the utilization of such reproductive health services among women [21]. Involving men in outreach could increase contraceptive adoption and continuation rates. For example, a study in Ethiopia found that couples in which the husbands participated in home-visit talks were more likely to initiate contraceptive use and to be using modern contraception one year after the visit than couples in which only the wife participated [84].

In countries where contraceptive prevalence has plateau at approximately 30-40%, overtures to men could yield new acceptors. Just as making more contraceptive methods available raises contraceptive prevalence involving men in family planning could increase prevalence in several ways: by providing alternatives to couples dissatisfied with their current method; by increasing male contraceptive use; by promoting greater discussion between sexual partners; and by changing male attitudes regarding contraception thereby enabling women to practice contraception [7].

Involvement of Men in Women's Reproductive Health

If there are few evaluated reports about men's involvement in family planning, there are even fewer about men's involvement in the maintenance of women's reproductive health. Toubia [85] reported on a program in Mali, which aimed to encourage men to accompany their spouses to family planning and gynecological services. During the Indian program, men were given information about antenatal care services, information about diet, nutrition and weight gain during pregnancy, and information about contraception. Using information gleaned from 113 structured interviews and 13 in-depth interviews, the study compared an intervention group with a nonintervention group. Men from the intervention group had a greater knowledge of the importance of antenatal care services, and their partners made more visits to antenatal care clinics.

Involvement of Men in ANC and PNC

Study of Premi and Mitra [70] reveals that the frequency of Baiga males' involvement in Antenatal Care (ANC) increases when their wives have had ANCs at least once in the past. This creates in them a sense of awareness of the mandatory nature of ANCs. They were seen escorting and accompanying their better halves thereafter to subsequent ANC check-ups. On the other hand, if the ANCs are alone at home, then, in such a case they do not feel the need of any involvement in their wives' ANCs, as they could depend on the other members of the family for needed assistance. Determinant of male involvement in Postnatal Care (PNC), their educational status and that of their wives, the benefits taken from ANCs, are to PNCs- such services, their involvement in ANCs, their being advanced in age at the time of their marriage, and their wives' taking advantage of the PNC facility by undergoing the investigations at least once earlier - such are the prominent features and aspects of male involvement.

Men and the Encouragement of Accountable Paternity

Although there have been a number of recent

ethnographic studies that have examined aspects of fatherhood in various developing countries, there were only two reports of an intervention in a developing country that aimed to foster men's involvement with their children. Johnston-Pitt and Jiji [43] reported on a Jamaican initiative, 'Fathers Incorporated'. Fathers Incorporated was a club for men that was set up to promote a positive image of responsible fatherhood. Both reports were descriptive, rather than analytical, but were included because they gave details about the only program documented evaluating men's in sexual health promotion 393 in the literature that was specifically set up to promote responsible fatherhood.World Health Organization, Geneva [94] recommended. Men have a unique role to play in promoting safe motherhood; they should not be viewed as passive onlookers or mere obstacles. Men could be as greatly affected by the social, cultural and economic complexities of safe motherhood as women they needed to be adequately informed and involved. Men are adversely affected by the deaths of their wives and female relatives; they need support to recognize factors which contribute to maternal deaths. Men receive little support to encourage their involvement in and knowledge of pregnancy and delivery of care. In some settings, men are receptive and eager to participate in safe motherhood campaigns and to be active partners for their wives during pregnancy and child birth. Women want men to be involved as partners or advocates for greater access to care and a better understanding of their needs during and following pregnancy. In most countries the public sector may provide routine support, but male involvement programmes have not been regarded as a public sector issue. Reason why there is a need to outline a set of interventions for men that can be tested. Research should provide a basis for the development of policies for male involvement. Support should be provided for operations research at the country level to test relevant intervention programmes. Society should mobilize support to put as much pressure on men as on women research should identify the constraints on mobilizing men. More research is needed on the socioeconomic impact of maternal deaths, in particular in young mothers.

Male's Contribution on Female's and Children's Health

The ways in which men influence women's health are numerous [26]. As husbands, boyfriends, fathers, brothers, and friends, men can have a positive effect on women's health by: using or supporting the use of contraception such that sexual partners are able to control the number and timing of pregnancies; encouraging women to have adequate nutrition during pregnancy and providing the needed physical, financial, and emotional support. Involving men in reproductive health has been found to have a positive impact on women's and children's health in a number of ways, including improving MCH care, preventing or reducing STI/HIV/AIDS transmission, and improving contraceptive use-effectiveness and continuation. Furthermore, men participating in antenatal education tend to know more about family planning methods and are more concerned about their partner's nutritional needs during pregnancy [72]. A study in Egypt has found that husbands who received counseling at the time of their wives' abortions were more likely to be supportive during the recovery period [1]. Enlisting men in the fight against STI/HIV/AIDS is particularly important given that men frequently transmit STIs to their monogamous partners. Research has shown that married women's greatest risk factor for STIs is the sexual behavior of their husbands [36, 27]. Men are much more likely (eight times) to transmit HIV to women through repeated acts of unprotected sexual intercourse than vice versa [64]. Studies have shown that involving men can increase contraceptive adoption, client satisfaction, contraceptive use effectiveness, and contraceptive continuation. Randomized trials have found that contraceptive adoption was significantly higher among women whose husbands were included in contraceptive counseling compared to women whose husbands were not involved [24, 84]. Several studies have shown higher contraceptive continuation among clients whose husbands have been involved in contraceptive counseling. A study in Madagascar found that women were more likely to continue using Norplant implants if their husbands had been involved in the counseling process [82] .

Involvement of Men in the Prevention of Unnecessary Pregnancy

Many of the reports available in the literature are less about the effectiveness of men's involvement. Evaluating men's in sexual health promotion 391 than about evaluating family planning services and making suggestions about the ways services might change to involve more men. Reports/ research in this genre include Premi and Mitra, [70] report of AVSC International's (now Engender health) [3] 'Men as Partners Initiative' and Wells' [90] reviews on reproductive and sexual health services for men, and the Johns Hopkins University [42] review of 20 men's family planning programs from Africa, Asia and Latin. These reports found that, contrary to what

some supposed many men wanted to be involved in family planning programs and that those programs in which men were viewed as caring partners rather than as irresponsible adversaries were successful in involving men. There are a number of reports of interventions that have involved men in family planning programs. AVSC International [2] presented findings from the eight family planning clinics that they had run in Colombia since 1985. The study found that the clinics were successful in attracting male clients. AVSC attributed this success to their policy of offering a brief counseling session to help men articulate their needs and talk about their doubts before they attended medical consultations. Another important element cited by the report was the policy of encouraging couples to seek services together. In Pakistan, AVSC International [3] carried out six case studies to evaluate affiliated projects that aimed to increase men's involvement in family planning. The study found that the projects were successful at reaching out to and involving men through a combination of extensive outreach work, the introduction of 'no scalpel' vasectomies, and regular meetings with the press, religious and political leaders aimed at promoting changes in the women's status and a reduction in family size. Population Council [67] reported on a program in Honduras designed to increase men's knowledge of family planning and to facilitate their role in reproductive decision making. Two strategies were used: one involved agricultural extension workers who were trained to give health education sessions based on a training manual, and the second extended an agricultural program, the 'Farm Management Plan', into areas of family planning through the use of a 'family man booklet. The program managed to involve men through low-cost strategies that were incorporated into already existing structures. There are several reports of interventions that successfully used interpersonal methods to increase men's knowledge of contraception and communication. These included: involving Muslim religious leaders in Bangladesh [62] in a program to teach about the connections between family planning and Islam; a peer education program amongst Tanzanian men; [66] seminars for health staff and a child spacing club based around a Malawi hospital and the training of agricultural extension workers to provide family planning information to men [67]. There are also several reports of mass media approaches that have targeted men's participation in family planning. Both Piotrow et al [65] and Kim and Muchek [46] evaluated the Zimbabwean Family Planning Council's 'Male Motivation Project'. The project used a wide variety of media: TV, radio, newspaper advertisements and articles, and a television soap opera. It also used language and images from competitive sport. Both studies found that men exposed to the campaign were significantly more likely to use condoms than men who were not. In one of the very few studies to test the efficacy of health education theory against the realities of men's involvement, actual evidence in the literature about the impact of men's involvement in the prevention of unwanted pregnancy, including increasing their own use of contraception and facilitating their partners' use, is generally sparse. Terefe and Larson's [83] report of a project for Ethiopian men are one of the very few studies to be actually concerned with evaluating the effectiveness of men's involvement as a health-promoting argument.

Data on men's attitudes toward family planning have only recently been collected. Research suggests that in many regions men view family planning favorably and can have a strong influence on the use of contraception. For example, research in Kenya suggests that contraception is two to three times more likely to be used when husbands rather than wives want to cease childbearing. [15] Results from Demographic and Health Surveys in 17 different nations in Asia, North Africa, East Africa, and West Africa support the following overall conclusions: Men and women have similar reproductive preferences and attitudes toward family planning (with the exception of West African countries). Men are no more opposed to family planning than women. Men tend to identify reproduction as a female responsibility [68]. In many countries, men are as favorable to condom use as women. Men's approval for and intentions to use family planning methods are similar to women's (with the exception of West African countries) [22, 74]. Some men are suspicious of family planning programs, believing they undermine men's power [61]. Results such as these are supported by qualitative studies. For example, a study of male involvement among five generations of a South Indian family found that men readily accepted condom use and vasectomy, even though they may not have liked some of the specific characteristics of the method [44]. Additional research is needed on both men's and women's attitudes toward use of and decision-making regarding reproductive health care services, with particular emphasis on how differences between men and women affect women's equality in decision-making.

Deterrence of Stds and Aids

The emergence of the AIDS pandemic has created

vastly increased interest in condom promotion, since the two major ways to prevent sexual transmission to HIV that causes AIDS are (a) changes in sexual behaviours (such as abstinence, monogamy and non-penetrative sex) and (b) condom use. Faced with the urgent need to control AIDS transmission and to give more attention to STD prevention and treatment, and since condoms are also a key means of protecting both men and women form STD infection, many Governments have permitted condom advertising in the mass media and have endorsed condom distribution and promotion initiatives. The HIV/AIDS pandemic has reached such an extent that educating men directly on the risks and consequences of HIV/AIDS and STDs should be regarded as a compulsory basic strategy in effective AIDS and STD preventions programmes.

Male Responsibilities and Participation

Men play a key role in bringing about gender equality since, in most societies; they exercise preponderant power in nearly every sphere of life. The objective is to promote gender equality and to encourage and enable men to take responsibility for their sexual and reproductive behaviour and their social and family roles. Governments should promote equal participation of women and men in all areas of family and household responsibilities, including, among others, responsible parenthood, sexual and reproductive behaviour, prevention of sexually transmitted diseases, and shared control in and contribution to family income and children's welfare. Governments should take steps to ensure that children receive appropriate financial support from their parents and should consider changes in law and policy to ensure men's support for their children and families.

Empowerment and Status of Women

The empowerment of women and improvement of their status are important ends in themselves and are essential for the achievement of sustainable development. The objectives are: to achieve equality and equity between men and women and enable women to realize their full potential; to involve women fully in policy and decision-making processes and in all aspects of economic, political and cultural life as active decision-makers, participants and beneficiaries; and to ensure that all women, as well as men, receive the education required to meet their basic human needs and to exercise their human rights. Recommended actions include, among others, establishing mechanisms for women's equal participation and equitable representation at all levels of the political process and public life; promoting women's education, skill development and employment; and eliminating all practices that discriminate against women, including those in the workplace and those affecting access to credit, control over property and social security. Countries should take full measures to eliminate all forms of exploitation, abuse, harassment and violence against women, adolescents and girls. In addition, development interventions should take better account of the multiple demands on women's time, with greater investments made in measures to lessen the burden of domestic responsibilities, and with attention to laws, programmes and policies which will enable employees of both sexes to harmonize their family and work responsibilities.

Integrating Population and Development Strategies

There is general agreement that persistent widespread poverty and serious social and gender inequities have significant influences on, and are in turn influenced by, demographic factors such as population growth, structure and distribution. There is also general agreement that unsustainable consumption and production patterns are contributing to the unsustainable use of natural resources and to environmental degradation. Section A seeks to integrate population concerns fully into development strategies and into all aspects of development planning at all levels. The sustained economic growth that results will help meet the needs and improve the quality of life of present and future generations. It will also promote social justice and help eradicate poverty.

Since ICPD Cairo [41] male involvement in reproductive health has become a fashionable topic and is mentioned in most forums addressing the issues of reproductive health, gender equity and empowerment of women. Very little however is known about how to enhance male involvement. Given the patriarchal social structure of South Asian countries, bringing about changes which strive to enhance male involvement and the gender equity this implies, is not easy.

Against this backdrop, it is interesting to take a look at how the Ministry of Health and Family Planning, Government of India, which is committed to implementing ICPD Programme of Action, is addressing these issues. What efforts have been made either by government or by NGOs to involve men in reproductive health and safe motherhood and what results have been achieved? Are innovative and replicable model(s) to enhance male involvement available?

Conclusion

Side by side such deliberations as recapitulated above, as an avowed and ardent student of anthropology. I learnt that all information and facts related to a society come to the fore only when they are studied in a prescribed method. So, such anthropological studies should be encouraged and recognized by government and its agencies. Side by side, the researchers in anthropology following the traditional and most credible method - "Ethnography" should compile and marshal the authentic, credible and verified information and facts. Or, they must pile up at least 3 to 6 months "participant observation". This has several advantages. By this process we can do cross-validation and cross- verification of the information collected and arrive at a more tangible and realistic principle. With more reliable authentic information and facts garnered, help in the progression and development of the society and the nation. Thus can be propounded the credibility and importance of the role of anthropologists and the participant observation - such a method's traditional recognition and superiority in anthropology can be re-established given a sound footing[69].

Acknowledgement

I wish to record my sincere gratitude and great honor to University Grant Commission, Ministry of Human Recourse Development, New Delhi for sanctioning minor research project.

References

1. Ablel-Tawab N, Huntintol D, Hassan ED. Youssef H, Nawar N. Counseling the husband of post abortion patients in Egypt: Effects on husband involvement patient recovery and contraceptive use. Final Report, Population Council; Asia and Near East Operations Research and Technical Assistance Project, Cairo .1997.
2. AVSC (now Engender Health). Men as partners in reproductive health. Workshop Report. Mombasa, Kenya. 1997a.
3. AVSC (now Engender Health). Men as partners in reproductive health. Workshop report. USA. May, 1997b.
4. Batchelder HP, Powell TM. Physical and biological conditions and processes in the Northeast Pacific Ocean. Prog. Oceanogr. 2002; 53: 105-114.
5. Bourgois PI. In search of respect: Selling crack in El Barrio. Cambridge: Cambridge University Press. 1995.
6. Browner CH, Sargent CF. Anthropology and studies of human reproduction. In: Sargent CF, Johnoson TM, editors. Medical anthropology: Contemporary theory and method. Westport, CT: Praeger. 1996; p. 219-234.
7. Bruce J, Jain A. Improving the quality of care through operations research. In: Seidman M, Inhorn MC, editors. Operations Research: Helping Family Planning Programs Work Better. New York: Wiley-Liss. 1991; p. 259-282.
8. Cianfrani T. A short history of obstetrics and gynecology. Springfield, III: Charles C. Thomas, Publisher. 1960.
9. Collumbien M, Hawkes S. Missing men's messages: Does the reproductive health approach respond the men's sexual health needs? Culture, Health and Sexuality. 2000; 2(2): 135-150.
10. Connell RW. Masculinities. Berkeley: University of California press. 1995.
11. Connell RW. Gender and power: Society, the person, and a sexual politics. Stanford: Stanford University press. 1987.
12. Courtenay WH. Constructions of masculinity and their influence on men's well-being: A theory of gender and health. Social Science & Medicine. 2000; 50: 1385-1401.
13. Deruisseau LG. Ancient pediatrics. Ciba Symposia. 1940; 2(5).
14. Dixon Muller R. The sexuality connection in reproductive health. Studies in Family Planning. 1993; 24(5): 269-282.
15. Dodoo FN. Men matter: Additive and interactive gendered preferences and reproductive behavior in Kenya. Demography. 1998; 35(2): 229-242.
16. Doyal L. Gender equity in health: Debates and dilemmas. Social science & Medicine. 2000; 51(6): 931-939.
17. Drannan M. Reproductive Health: New perspectives on men's participation. Population Reports, Series. 1998; 1(46): 36.
18. Dudgeon MR, Inhorn MC. Men's influences on women's reproductive health: Medical anthropological perspectives. Social Science & Medicine. 2004; 59: 1379-1395.
19. Dudgeon MR, Inhorn MC. Gender, masculinity, and reproduction: Anthropological perspectives. International Journal of Men's Health. 2003; 2: 31–56.
20. Elwin V. The Baiga. London: John Murray Eschen and Whittaker. 1939.
21. Ezeh AC. The influence of spouses over each other's contraceptive attitudes in Ghana, Studies in Family Planning. 1993; 24(3): 163-174.
22. Ezch AC, Scroussi M, Raggers H. Men's fertility,

contraceptive use, and reproductive preferences. Demographic and Health Surveys Comparative Studies. 1996; Calverton, MD, USA: Macro International, No. 18.

23. Farmer P, Connors M, Simmons J. Women, poverty, and AIDS: Sex, drugs, and structural violence. University of Michigan: Common Courage Press.1996.
24. Fisek NH, Subuloglu K. The effects of husband and wife education on family planning in rural Turkey. Studies in Family Planning. 1978; 9(10-11): 280-285.
25. Ford CS. A. comparative study of human reproduction. New Haven: Yale University Publication in Anthropology No. 32 (Orig. 1945). Reprinted by HRAF Press.1964.
26. Foumbi J, Lovich R. The role of men in the lives of children. New York: UNICEF.1997.
27. Foreman M. AIDS and men: Taking risks or taking responsibility. London: Panos Institute. 1999.
28. Gallen ME, Liskin L, Kak N. Men- new focus for family planning programs. Population Reports Series J, No. 33. Baltimore, John Hopkins School of Public Health, Population Information Program. 1986; 32.
29. Grady WR, Tanfer K, Billy JOG, Lincoln-Hanson J. Men's perceptions of their roles and responsibilities regarding sex, contraception, and childrearing. Family Planning Perspectives. 1996; 28(5): 221-226.
30. Gutmann MC. Trafficking in men: The anthropology of masculinity. Annual Review of Anthropology. 1997; (26): 385-409.
31. Harper J, Jezowski TV. Men and family planning: A special initiative. AVSC news. October, 1991.
32. Harrell DE. The South: Seedbed of sectarianism. Varieties of Southern Evangelicalism. 1981; 45-58.
33. Herdt G. Inter-Generational relation and AIDS in the formation of gay culture in the United States. In: Levine M, Nardi P, Gagnon J, editors. In changing times: Gay men and lesbian encounter. Chicago: University of Chicago press. 1997; p.245-82.
34. Himes NE. Medical history of contraception. New York: Schocken Books.1970. (Orig.: The Williams & Wilkins Co. 1935).
35. Howell N. Demography of the Dobe !Kung. New York: Walter de Gruyter, Inc. 1979.
36. Hunter DJ, Maggwa BN, Mad JK, Tukei PM, Mbugua S. Sexual behaviour, STDs, male circumcision and risk of HIV infection among women in Nairobi, Kenya. AIDS. 1994; 8(l): 93-99.
37. Inhorn MC. Sexuality, masculinity, and infertility in Egypt: Potent troubles in the marital and medical encounters. Journal of Men's Studies. 2002; 10: 343-359.
38. Inhorn MC. Global infertility and the globalization of new reproductive technologies: Illustrations from Egypt. Social Sciences and Medicine. 2003; 56: 1837-51.
39. Inhorn MC, Whittle LK. Feminism meets the "new" epidemiologies: Toward an appraisal of antifeminist biases in epidemiological research on women's health. Social Science & Medicine. 2001; 53: 553-567.
40. Inhorn, MC. Quest for conception: Gender infertility and Egyptian medical traditions. Philadelphia: University of Philadelphia press. 1994.
41. International Conference on Population and Development (ICPD). Programme of Action. United Nations Population Fund: Cairo.1994.
42. Johns Hopkins University Center for Communication Programs. Men: Key partners in reproductive health, A report on the first conference of French-speaking African on men's participation in reproductive health. 1998.
43. Johnston-Pitt D, Jiji J. Promoting responsible reproductive behaviour in Jamaica. Fathers and teens. POPULI. 1996; 23(2): 6-8.
44. Karra MV, Stark NN, Wolf J. Male involvement in family planning: A case study spanning five generations of a South Indian family. Studies in Family Planning. 1997; (28)1: 24-34.
45. Kesslesr SJ, McKenna W. Gender: An ethnomethodological approach. New York: Wiley.1978.
46. Kim YM, Kols A, Mucheke S. Informed choice and decision making in family planning counseling in Kenya. International Family Planning Perspective. 1998; 30(14): 11- 42.
47. Klein AM. Life's too short to die small: Steroid use among male bodybuilders. In: Sado DF, Gordon D, editors. Men's health and illness: Gender, power, and the body. Thousand Oaks, CA: Sage. 1995; p. 105-120.
48. Kleinman A. International health care planning from an ethnomedical perspective: Critique and recommendations for change. Medical Anthropology. 1978; (2)2: 71-96.
49. Krieger N, Fee E. Made medicine and women's health: The biopolitics of sex gender and race\ethnicity. International Journal of Health Services. 1994; 24(2): 265-283.
50. Lancaster RN. Life is hard: Machismo, danger, and the intimacy of power in Nicaragua. Berkeley: University of California Press. 1992.
51. Landy D. Medical system and theories of disease and healing. In: Landy D, editor. Studies in medical anthropology. New York: Mcmillan Publishing Co. Inc. 1977; p.129-132.
52. Lane SD, Rubinstein RA. International health: Problems and programs in anthropological perspective. In: Sargent C F, Johnson TM, editors. Medical anthropology: contemporary theory and method. Westport, CT: Praeger. 1996; p. 96-423.

53. Malinowski B. Argonauts of the Western Pacific. Long Grove, 1260047-9580, USA Mason and Lynam: Waveland Press, Inc. 1922.

54. Mbizvo MT. Reproductive and sexual health: A research and developmental challenge. Central African Journal of Medicine. 1996; 42(3): 80-85.

55. Mbizvo MT, Bassett MT. Reproductive health and AIDS prevention in Sub-Saharan Africa: The case for increased male participation. Health Policy and Planning. 1996; 11(1): 84-92.

56. Mead M. Male and female. New York: Harper Collins Publishers Inc. 1949.

57. Mead M. Coming of age in Samoa: A psychological study of primitive youth for western civilization. New York: William Marrow & company. 1961.

58. Montagu A. Embryological beliefs of primitive peoples. Ciba Symposia. 1949; 10: 994-1008.

59. Moynihan C. Theories in health care and research: Theories of masculinity. British Medical Journal. 1998; 317: 1072-1075.

60. Morgran LM. Community participation in health: The politics of primary care in Costa Rica. Cambridge: Cambridge University press. 1993.

61. Ndong I. Finger WR. Male responsibility for reproductive health. Network. 1998; 18(3): 4-6.

62. Neaz A. Converting Bangladesh's influencing religious leaders' in international planned parenthood federation challenge: Men's needs and responsibilities. London: IIPE. 1996.

63. Oppenheimer J M. Essays in the history of embryology and biology. Cambridge, Mass.: The M.I.T. Press. 1967.

64. Padian NS, Shiboski SC, Glass SO, Vittinghoff E. Heterosexual transmission of human immunodeficiency virus (HIV) in Northern California: Results from a ten-year study. American Journal of Epidemiology. 1997; 146(4): 350-357.

65. Piotrow PT, Kincaid DL, Hindin MJ, Lettenmaire CL, Kuseka L, Silberman T, et al. Changing men's attitudes and behavior: The Zimbabwe male motivation project. Studies in Family Planning. 1992; 23(6): 365-375.

66. Popoola, D. Involving men in reproductive health advocacy in the United Republic of Tanzania. Promotion and Education. 1999; 6: 20–23.

67. Population Council. Getting men involved in family planning: Experiences from an evocative program. Final report, Population Council: Dhaka, Bangladesh. 1998.

68. Population Reports. Series L, No. 11. Baltimore: Johns Hopkins University School of Public Health, Population Information Program. December, 1999. Available from: http://www.infoforhealth.org/pr/l11edsum.shtml.

69. Premi JK, Mitra M. Need based interventions for improvement of reproductive health and male involvement of the Baiga tribe of Chhattisgarh (India). International Journal of Advances in Social Sciences. 2013a; 01(02): 51- 57.

70. Premi JK, Mitra M. Perspectives of behavior and involvement of men in reproductive health: A bio-cultural exploration of the Baiga tribe of Chhattisgarh. School of studies in anthropology: Pt. Ravishankar Shukla University, Raipur, Chhattisgarh, India. Unpublished Ph.D. thesis. 2013b.

71. Presser HB, Sen G. Women's empowerment and demographic processes: Moving beyond Cairo. Oxford: Oxford University Press. 2000.

72. Raju S, Leonard A. Men as supportive partners in reproductive health: moving from rhetoric to realty. Population (council). 2000. Available from: www.popcouncil.org/pdfs/menaspartners.pdf.

73. Roaaldo MZ. Woman, culture, and society: A theoewyixal overview. In: Rosaldo MZ, Lamphere L, editors. Woman, Culture, and Society. Stanford: Stanford University Press. 1974; p. 17-42.

74. Roudi F, Ashford L. Men and family planning in Africa (Chart book of DHS data). Washington, DC: Population Reference Bureau. 1996.

75. Roy K, de Vargas P. Women's perceptions – providers' challenges: Clients on partner participation in reproductive health services. (INOPAL final report). Population Council, Latin America and the Caribbean Operations Research and Technical Assistance in Family Planning and Reproductive Health. New York. 1999.

76. Sabo D, Gordon DF. Rethinking men's health and illness: The relevance of gender studies. In: Sabo D, Gordon DF, editors. Men's health and illness gender, power, and the body (Vol.8). London: Sage. 1995.

77. Sargent CF, Brettell CB. Gender and health, an international perspective. Prentice-Han, Upper Saddle River, New Jersey: Schehl and Green's. 1996.

78. Seidler VJ. 1994. Unreasonable men: Masculinity and social theory. London: Routledge.

79. Shostak M. Nisa, the life and words of a !Kung women. New York: Vintage Books 1983.

80. Spencer RF. Primitive obstetrics. Ciba Symposia. 1949; 11: 1158-1188.

81. Spencer RF. Embryology and obstetrics in preindustrial societies. In: Landy D, editor. Culture, disease and healing: Studies in medical anthropology. New York: Macmillan Publishing Co. 1977.

82. Tapsoba P, Miller R, Ralalahariventy LR. Involving husbands to increase the acceptability of Norplant in Antananarivo, Madagascar. Paper presented at the annual meeting of the American Public Health Association, in San Francisco, CA. October 24-28; 1993.

83. Technical Report. Population Council. Getting men involved in family planning: Experiences from an

evocative programme. Population Council: Dhaka, Bangladesh. 1998.

84. Terefe A, Larson CP. Modern contraception use in Ethiopia: Does involving husbands make a difference. American Journal of Public Health. 1993; 83(11): 1567-71.
85. Toubia 1995. Toubia N. Female genital mutilation: a call for global action. New York: Women, Ink. 1993.
86. Tripp-Reimer T, Wilson SE. Cross-cultural perspectives on fatherhood. In: Bozett FW, Hansom SMH, editors. Fatherhood and families in cultural context. New York: Spinger Publishing Company; 1991. p. 1-27.
87. Vlassoff C, Manderson L. Incorporating gender in the anthropology of infectious diseases. Tropical Medicine and International Health. 1998; 3(12): 1011-1019.
88. Ward VM, Bertrand JT, Puac F. Exploring Sociocultural barriers to family planning among Mayans in Guatemala. International Family Planning Perspectives. 1992; 18: 59-65.
89. Webb RE, Daniluk JC. The end of the line: Infertile men's experiences of being unable to produce a child. Men and masculinities. 1999; 2: 6-26.
90. Wells,A. Cognitive therapy of anxiety disorders: A practice manual and conceptual guide. Chichester, Sussex:Wiley. 1997.
91. World Health Organization. Challenges in Reproductive Health Research: Executive Summary. Biennial Report. Geneva, UNDP/UNFPA/WHO/ World Bank Special Programme of Research, Development and Research Training in Human Reproduction. 1993a.
92. World Health Organization. Challenges in Reproductive Health Research: Executive Summary. Biannual Report. Geneva: UNDP/UNFPA/WHO/ World Bank Special Programme of Research, Development and Research Training in Human Reproduction. 1993b.
93. World Health Organization. Health, Population and Development. Paper presented at the International Conference on Population and Development: WHO/ FHE/94.1 in Geneva. 1994.
94. World Health Organization. Programming for male involvement in reproductive health. Report of the meeting of WHO regional advisers in reproductive health WHO/PAHO: Washington, DC. 2002.
95. Zeidenstein S, Moore K. Learning about sexuality: A practical beginning. New York: Population Council. 1996.