PROVIDER BIAS OR ORGANIZATIONAL LIMITATIONS? FEMALE AND MALE HEALTH CARE WORKERS’ INTERACTION WITH MEN IN REPRODUCTIVE HEALTH PROGRAMMES IN RURAL CENTRAL INDIA

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INTRODUCTION

In reproductive health programmes, quality of the client-provider interaction is known to have a strong influence on initial adoption, effective use, and continuation of family planning methods, as well as on word-of-mouth favorable publicity about family planning and other reproductive health services. Guidelines for client-provider interaction generally assume that the client is a woman. However, the last fifteen years have witnessed increasing global recognition of the importance of men’s involvement in sexual and reproductive health (SRH). Issues such as the AIDS epidemic have reinforced the urgency of encouraging men to take responsibility for their own sexual and reproductive health and that of their partners.

The International Conference on Population and Development (ICPD) in 1994 called on organizations that historically had provided family planning and other reproductive health services to women, to constructively involve men in their programmes for the benefit of both men and women. The National Population Policy (2000) of India too emphasized an increased male participation in planned parenthood. Gender inequalities in patriarchal societies ensure that men play a critical role in determining and making decisions on key areas like education, employment and marriage, besides access to and utilization of health, nutrition, and family welfare services for women and children. It is, therefore, essential to include them in programmes for increased reproductive health outputs for both men...
and women. Currently, with regard to family planning services, over 97 percent of sterilizations in India are performed on women. Public family health strategies both at national and state levels have acknowledged the need to correct this manifestation of gender imbalance. According to the National Population Policy, the special needs of men include re-popularizing vasectomies, in particular non-scalpel vasectomy as a safe and simple procedure, and focusing on men in the information and education campaigns to promote the small family norm.

Despite global recognition at the level of international agreements as well as finding a mention in the national and state programme policies, India has not developed large-scale programmes that effectively reach out to men. Involving men is particularly challenging in countries whose culturally defined gender roles may discourage men’s participation. Women’s health advocates and feminists initially asked whether involving men risked diverting resources from women and encroached on their reproductive freedom. These concerns, however, have lessened with the growing recognition, spurred on by the HIV epidemic that reproductive health of individuals largely depends on a relational act occurring between two people. The potential benefits of men’s involvement include increased rights for women, improved family health, better communication between partners, and joint and informed decision making within households. Empirical evidence shows convincingly that men exhibit poor reproductive health knowledge and underutilization of reproductive health services in India. A survey in India and an intervention study in Pakistan each documented that even educated men lacked knowledge about reproductive health issues.

During India’s state of emergency between 1975 and 1977, an infamous family planning initiative began in April 1976, conducting vasectomy of thousands of men under coercive conditions. The then Prime Minister Indira Gandhi’s son, Sanjay Gandhi, was largely blamed for what turned out to be a failed programme. The highly controversial programme was followed by strong resistance to any male-oriented family planning initiative, which has continued into the 21st century. Grassroots health workers have since then interfaced more with women in communities rather than men for family planning information and services. This historic focus on services targeted at women has led to men being neglected in the reproductive health information and services network, often to the detriment of both men and women. Consequently, since the late 1990s, governmental policies at the strategic level have addressed the need to involve men. However, it is not yet clear how the strategy aimed at addressing men has been played out in the rural reality. Health provider-potential male client interface is still limited, and there is a lack of clarity with regard to the underlying factors. Systemic factors, such as the fieldworkers’ lack of strategic knowledge and structural weaknesses in the organization of the family health programme needs to be ascertained along with the extent to which lack of interaction with male clients derives from provider bias against men.

This article examines the extent, motivation, and prevalence of village-level health workers’ interaction with men concerning reproductive health issues in rural central India. The main interest is in the initial contact points in the households and villages where fieldworkers visit to promote family planning and provide information on reproductive health services.
Conceptual framework

The interaction between a health provider and a potential client, in this case a male client, brings together a health worker who is part of the public health care system, and a man who is motivated, consciously or otherwise, by his and/or his partner’s sexual and reproductive health objectives. The occurrence and nature of this interaction reflects a number of limiting conditions: the health provider’s strategic awareness and interactive skills, and the man’s awareness of his own or his spouse’s motivation, level of knowledge and service needs (Figure 1). At the baseline, all these factors are affected by the gender ideology that manifests values, norms and asymmetrical opportunities available for men and women.

In this study, we concentrate particularly on two parts of this complex picture, namely the organizational structures and provider bias which is defined here as ‘the attitude of a provider who provides services only to individuals who he/she is comfortable with, or who does not feel the need to reach out to a particular group with reproductive health information with the understanding that it may not be beneficial to them’. Provider bias against men in sexual and reproductive health in developing countries has attracted attention only as part of wider male involvement issues. However, most studies of male client-provider interaction in the developing world deal with the issue in the context of non-governmental organizations’ experiences. In this study, we examine this interaction in the public service provision.

FIGURE 1
Conceptual framework of factors relating to male client-health provider interaction
PUBLIC HEALTH SYSTEM
**Methodology**

*Structure of the rural health care system in India*

India's rural health care system is well established and it reaches out to the micro-interiors of the country.

With its three-tier structure in the public sector, a sub-health centre (Sub-centre) is the most peripheral and first contact point between the primary health care system and the community. As per the population norms, one Sub-centre is established for every 5000 population in plain areas and for every 3000 population in hilly/tribal/desert areas. At the next tier is the Primary Health Center (PHC) that caters to a population of 30,000 people. The tertiary health unit is the Community Health Centre (CHC), which is based at the district headquarters and caters to a population of about 1,20,000 population. All these referral units are equipped with personnel and equipment to carry out a range of health services under sexual and reproductive health, including pregnancy, postpartum, family planning, child health and immunization, and general health care. An Auxiliary Nurse Midwife (ANM), a female paramedical worker posted at the sub centre, supported by a Male Multipurpose Worker (MPW-M) are the front line workers in providing Family Welfare Services to the community. A Lady Health Visitor (LHV) posted at the PHC supervises the ANM.17

The daily routine of the ANMs is built on monthly route plans. During their usual course of work, they visit antenatal care (ANC) women regularly, conduct check-ups for babies up to 3 years of age, distribute contraceptives (oral pills and condoms), motivate female sterilization clients during their home visits and monitor the health of families in their area. Most of the interactions of the ANMs are in homes of people and mostly with women of the household. Usually, health care centers are over-burdened and struggle to provide services with limited personnel and equipment. Absence of supportive supervision, lack of training in interpersonal communication, and lack of motivation towards their work in rural areas, together impede citizens' access to reproductive and child health services, and contribute to poor quality of services and an apparent insensitivity to client's needs.5

To meet the health needs of the population, especially at grassroots level, a multipurpose health workers programme was introduced in 1978, to undertake various tasks relevant to the promotion of health and prevention of disorders, with special emphasis on maternal and child health services. The Male Multipurpose Worker (MPW-M) mostly interacts with men in the community and is supervised by the Male Supervisor (MS). He also works towards the promotion of male sterilization, including non-scalpel vasectomy, which the government of India is trying to promote in order to encourage male involvement in family planning. He conducts discussions with men on various contraceptive methods and talks of condoms as a dual protection against pregnancy and STIs/HIV, in addition to his other public health promoting activities, which forms major part of his responsibility.

*The study setting*

The study was conducted in Sehore and Raisen, two districts of Madhya Pradesh, in central India from September to October 2005. The state has a total population of 60.4 million people, of which about 73 percent reside in rural areas. The total

*Since this 2005 study, the rural health care structure has been modified with the implementation of the National Rural Health Mission (NRHM) and now there is a network of Accredited Social Health Activists (ASHA) workers, who comprise of community peers who have been trained for any emergency health services in the villages.*
fertility rate is 3.12 for the state and 3.34 for rural areas, which is higher than the national rate of 2.68 and 2.98, respectively. About 70 percent of the residents of Madhya Pradesh depend on agriculture for their income. The sex ratio at birth is 933 females per 1,000 males, the birth rate is 32.3 per 1,000 persons, and about 50 percent of women and 70 percent of men are literate. In 2005, the contraceptive prevalence rate in Madhya Pradesh was 55.9 percent (54.1% in the rural areas), among which 46.9 percent of eligible couples were using female sterilization.

The data

The data reported here were collected from four categories of rural health service providers in two districts - Sehore and Raisen, about 50 km from the state capital, Bhopal, from August to September 2005. This cross-sectional study used qualitative in-depth interviews (IDIs) and broadly covered most of the health care provider categories serving rural areas, both male and female. The selection of respondents was purposive.

A list of Auxiliary Nurse Midwives (ANMs), Lady Health Visitors (LHVs), Male Supervisors (MS) and Male Multi-Purpose Workers (MPW-M) was gathered from the Block Extension Office at the District Headquarters. Participants were randomly selected and their availability was ensured and appointments sought before meeting them for individual interviews. The purpose of the interview was explained to each one of them as to understand their work, modus operandi and points of contact with the communities, especially with men in the community. Interviews were held with 20 ANMs, 6 LHVs, 8 MS and 16 MPW-M across the two districts. Discussions were also held with two senior Programme Managers - a Block Medical Officer (BMO) from the block headquarter and a Chief Medical Officer (CMO) from Sehore district.

Thus, a total of 52 interviews were conducted. Individual discussions were held with each of them based on a discussion guide that was pre-tested. The questions included socio-economic profile, number of years in service, training, profile of work, community interactions and extent of interaction with men during their work. The interviews were kept as free-flowing as possible in order to get all nuances pertaining to the health care workers’ interaction with men in the community. The data was analyzed using content analysis technique.

RESULTS

Profile of study participants

The average age of the respondent health workers ranged from 38 years to 55 years. They had 10 to 14 years of formal schooling after which each one had intensive training for the health service position that they were currently working, ranging from one month for the ANM training to one year for MPW training. Their experience in the current job spanned 7 to 14 years. All of them had undergone both theoretical as well as on-field training either prior to joining or while on the job, qualifying them as experienced workers. The block and district level health officers interviewed were trained medical doctors and had been in their current service position for about seven years, with a total of 15 and 25 years in service, respectively.

All the village level health workers belonged to similar rural backgrounds, spoke the same language as the communities they were serving, and had their homes and families in the same rural pockets.

The duties described by the interviewees corresponded to the ones expected from them according to the state family health organization’s guidelines.
Extent of interaction with men in the community

While the local health structure was well-defined and followed a particular programme, the segmentation of the population for information and service reach was based on the perceptions of the health workers per se rather than on what the programme addressed and advised. The local health workers took it for granted that they were expected to interact mainly with women for messages related to reproductive health and family planning. The interviews revealed that men are seldom addressed and hardly ever specifically targeted in the programme.

An ANM explained which was found typical of nearly all female interviewees:

"I do not interact with the men of the community. Even men do not come to me for any information and counseling on family planning or contraception. Their involvement on these issues is very less". (ANM1)

All the ANMs interviewed said that their discussions on RCH and FP at the community level are held mostly with women, at their homes:

"Discussions on RCH/FP are again held in people's homes, more on a one to one interaction. These are mainly held with women; we do not discuss with couples." (ANM4)

When the interaction is on a one-to-one basis at home, it becomes difficult for a female worker to address men. In rural India, it is considered inappropriate for a female worker to discuss such issues with a male, particularly if no one else is present and if she is herself actively bringing the topic to the fore. One ANM explained:

"No man has approached me on his own with any query regarding contraception or other related issues. It is not a priority to him since his wife is talking to us anyway". (ANM7)

Only one female village worker said that when there were discussions on condoms, men were involved in such discussions, but again, only if they were present during the health worker’s visit to their homes.

In general, the grassroots female health workers (ANMs and LHVs) do not have much interaction with men in the community. On the contrary, the male staff (MPWs and MS) interact more with men than women in the community as they are not limited by conceptions of propriety as much as women. However, male village workers also reported a non-enthusiastic audience in men with regard to information on reproductive health:

"We contact men since the ANM mainly interacts with women. However, not many men participate. Only one in four come for such discussions" (MS3)

The male multipurpose workers (MPWs) mainly counsel and discuss with men in the community. However, here too, they say that village women come forward for information more eagerly than men. As mentioned by one multi-purpose worker,

"Condoms are the most popular among men since they also prevent infections and diseases like AIDS. However, the women come to the forefront even to discuss condoms - the men do not take any interest" (MPW4)

Programme factors affecting interaction with village men

a. Awareness of male involvement policy among village workers

The National Population Policy as well as the Madhya Pradesh Population Policy clearly states the importance of involving men in the family planning programme. Health workers’ knowledge of the national and state policies on male involvement in reproductive health was assessed. Lack of reaching out to men as an outcome of the level of awareness on the issue among village level health workers was investigated. Further, has the policy interest failed to materialize due to blocks
in the information flow concerning strategic objectives?

The interview data shows that the local level workers lack information on strategic guidelines, although they are trained well to work on practical issues. The burden of everyday work experience is so high that the workers do not see themselves having any opportunity to familiarize themselves with policy papers:

“We are so overburdened with our work, that we do not have time to find out what is being said and where.” (ANM12)

On mentioning that they might have heard of the policy documents during their training programme, one ANM mentioned:

“We only remember being trained on our day to day work, number of villages to be covered, and how we should report our daily work. We do not remember any discussion on the (national or state) policy.” (ANM9)

Even local level Male Supervisors and Lady Health Visitors, who have a supervisory role, were ignorant about policy papers. When asked about the National Population Policy, a Male Supervisor countered:

“What does it say? We have no knowledge of it.” (MS2)

Implementation of the policy document seems to be missing at the grassroots level in rural India with none of the village level interviewees being aware of the state population policy, the National Population Policy or even the AIDS situation in the state, although they reportedly had undergone training on these issues. The health workers in rural Madhya Pradesh gave the impression that they are ignorant of the present strategies concerning male involvement in reproductive health.

Despite general ignorance on the strategic guidelines and policies among local health workers, some of the respondents understood the importance of male involvement. One interviewee recognized the need and willingness of rural men to know more and to participate. She understood the reason behind the need to involve men as one of the strong decision-making powers in rural setting which affects the health of women:

“Men do want to know and be informed about these issues. But in the village, men are not aware, they are shy to discuss such issues, and do not come out openly. And the problem here is that they are the decision makers in the family. It is a male-dominant society; the wife is dependent on the husband. So, it is very important that they be well informed”. (ANM9)

Another male village worker shared the same view and stressed how the involvement of men would also benefit women in rural areas:

“Both men and women are partners for life. However, in our societies, the man is dominant and so without his support, no service is possible. Therefore, involving both of them equally is very important for successful service delivery”. (MPW5)

Consequently, we may say that the health workers who are responsible to reach out to villagers are unaware of the strategic objectives of reproductive health policies in India. However, many male as well as female workers have come to understand the importance and motivation for male involvement in reproductive health through their activities in rural areas.

b. Access to men

One of the most evident explanations to the lack of interaction with men in the community relates to the access to men. The village workers are expected to make their rounds in villages and to visit houses, where they mostly discuss reproductive health issues with females. One of the ANMs explained:

“Husbands are mostly never available when we visit, so it is impossible to involve them in such discussions.” (ANM3)
Sometimes discussions are held in the anganwadi centers (child health centers) or in the fields, but even then, men are rarely encountered. Most health workers reported that men were usually busy at their fields or away from their homes when they went for home visits.

Some village-level workers also had suggestions for improving male involvement by providing more privacy and more individual interaction:

“I think that the best way to get men talking about the sexual and reproductive health issue is to discuss with them individually, in privacy. They do not open up in a group or even in front of other family members at their homes.” (MPW5)

c. Provider bias against men

Studies from various parts of the world have brought out reasons why men are not involved in reproductive health issues, or even if they are, their interaction is limited. Firstly, a programmatic exclusion criterion may lead to directing project activities to women only. Secondly, there is evidence of provider bias against male clients and of providers making men feel uncomfortable and unwelcome. Provider bias may lead to health providers failing to give men accurate information about male contraceptive methods such as vasectomy14 and violating their rights to privacy and confidentiality.16

Provider bias against men comes clearly through in the interview data as one of the reasons why outreach to village men remains limited. One of the basic tenets of a number of interviewees was that men are simply not interested in reproductive health issues:

"Men are less participatory or seem not interested in such issues when we visit their homes for discussions. However, in isolation/privacy, the men do discuss among themselves.” (ANM3)

Some of the interviewees perceived lack of active participation by men was due to their having the needed information and that men would ask for information and services if they required:

"Men are themselves wise and understanding. They do not need to know much. If the men want any specific information, they come to the ANM themselves.” (ANM6)

Health workers believed that men are not expected to be interested in family planning since women take the lead role in reproductive health issues. According to the male supervisors, men are more eager to let their wives get sterilized:

"The viewpoints of the men in the community are traditional and both men and women themselves also endorse these viewpoints due to misconceptions.” (MS2)

Although the Government of India has a clear objective of reducing reliance on women's contraceptive methods, male sterilization even in its new non-scalpel form is not gaining popularity in India. To understand what the health providers' perceptions were with regard to men's 'disinterest' when it came to reproductive health issues, they impromptu spoke about the governments' recent programme to intensify the popularity of non-scalpel vasectomy (NSV) among men. This, according to them, is a good method to make men take responsibility of family planning. But according to them, this programme too has not helped holding men's interest in family planning. Motivating men for the non-scalpel vasectomy has appeared to be hard, due to the gender ideology which posits females as the ones to take the onus and risks of family planning on their own bodies. According to the Block Medical Officer, "NSV programme has not picked up. Awareness itself is lacking about it. The health workers feel that motivating one man for NSV is equivalent to motivating fifty women for female..."
sterilization, so why not get women for female sterilization, which is the easier option?"

The Block Medical Officer’s comment indicate that behind the weak motivation that male workers might have to address men’s family planning needs, it is easy to give up when faced with the prevalent gender ideology, which allocates family planning as a woman’s duty. Men’s participation was doubted also in the higher administrative level by pointing out the failures of the NSV campaign:

"Last year, they performed only 6 NSVs of 6,000 sterilizations (the rest being female sterilization). So then where is the question of men’s participation?" (Block Medical Officer)

One Officer considered the whole task of addressing men very difficult due to cultural beliefs and the gender ideology:

"Getting men involved in family planning promotion programmes is like trying to bell the cat! It is more difficult than one can see. Men do not bear labour pains, so they are not guilty of not adopting family planning and do not take it as their responsibility. Even the women do not want their men to get sterilized due to misconceptions like men becoming weak after the procedure; they have to work hard so why should they bear this, and so on..." (Chief Medical Officer)

Clearly, local health workers, both those who are responsible for administration and those working in the field with communities, have provider bias in the promotion of male involvement in family planning, which they explain away as local gender ideology and male disinterest.

**DISCUSSION**

There is unequivocal acknowledgement among local health workers about the lack of male involvement in reproductive health in rural Madhya Pradesh. Despite lack of awareness about the strategic objectives related to male involvement and the pertaining policy papers, they appreciate the importance of reaching out to both men and women for effective family welfare implementation. Women are mainly the point of contact for the female health workers. Although they do acknowledge the importance of reaching out to men, they are not confident about the means. The only opportunity for interacting with them is during the women’s visits for antenatal or postnatal care along with their husbands, or when the husbands are at home during the health workers’ home-visits. Grassroots health care providers often construe men’s participation as disinterest with regard to reproductive health issues. Although the male health workers mainly interact with men in the community, they too find it difficult to involve men in providing services and information on reproductive health, including family planning. The importance of provider bias is different for male and female health workers. While for female health workers, lack of interaction with men in the community is mainly due to organizational limitations, followed by provider bias, for male health workers, provider bias is a major hindrance as compared to organizational limitations. Although men do not suffer from the limitations of male interaction in the prevailing gender system as compared to women, they fail to engage males.

It is evidenced that rural men want more personal information about sexual and reproductive health, and are worried about their wives’ health. Hence, there seems to be a huge mismatch between what the rural men feel and what the health workers think is the reality. At the moment, there is some contact with the men when women are being accessed. This combined outreach still does not serve the purpose as men would want specific answers to their questions. From the men’s perspective, they feel that only the women are targeted and that there is no effort to reach out to them about their own information needs. Women, on the other hand, seem to be easily accessible in the rural community.
and therefore, men are not specifically targeted in these programmes.

The execution of the maternal and child health programme in India is in need of a renewed understanding of practical forms of action that would best serve the strategic objectives of male involvement. The introduction of male village-level workers has evidently not been as effective as expected. The reasons why female workers have failed to address men's needs are mainly practical and cultural, as women can neither reach men at their homes nor can they easily take initiative in talking to them about reproductive health issues. The failure of the male village workers lies both in the organizational issues (absence of confidential one-to-one interaction) and provider bias against men. Organizational shortcomings relate more to health workers' current work pressures that preempt culturally possible contact with men. Couples are hardly addressed together, due to the fact that village workers go for home visits and men are rarely at home during the day. Reaching out to men through couple counseling would require meeting men who accompany their wives for attending antenatal or other services in the health centers. Encouraging this practice would require major organizational drive as well as facilities where the couple can be met in privacy, which are lacking in most rural health centers.

More difficult than combating organizational issues is the provider bias which is rooted in local gender ideology. When the onus of reproductive health and family planning is on women, the programme implementers easily give up their efforts to popularize such methods like non-scalpel vasectomy when facing resistance. If the local village workers themselves fail to believe in the possible active role of men in reproductive health issues, they may be transmitting their own skepticism in their interaction.

**CONCLUSION**

Health care providers need to make a conscious effort of reaching out to men with complete information. Training and sensitization of the health workers at all levels, including training them on the existing national and state policies and guiding them to programme implementation, will go a long way in ensuring greater reach to men in the communities. This is the need of the hour and more and more innovative strategies need to be developed in order to reach out to target men.

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