Chapter 12

Gender and Health Training of Male Multipurpose Workers

Challenges and Lessons Learnt from Mumbai

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Male health workers can link together men in need of reproductive health services, their partners, and health care providers (Piet-Pelon et al. 1999). Despite this potential role, identifying model programmes regarding male health workers is not without challenges. It is a common observation that male workers possess less information than their female counterparts. Furthermore, training and discussions with male workers reveal a range of concerns and apprehensions regarding sexuality, pregnancy, abortion and infertility (Raju & Leonard 2000). Lastly, there does not appear to be much experience in South Asia in training male health care providers on issues of sexuality and health, especially from a gender and rights perspective (Hawkes 2000). Reflecting on this gap, this paper describes the experiences of the Women Centred Health Project (WCHP) in training male health workers[1] in the Public Health Department (PHD) of the Municipal Corporation of Greater Mumbai (MCGM) on gender, sexuality, and health.

The project evolved from a research study on factors predisposing women from weaker socioeconomic strata to pelvic inflammatory diseases (PID). Women's lack of power to negotiate responsible sexual practices with their male partners was found to be one of the factors. Women study participants suggested that the public health care system should assume a greater role by reaching out to men and conveying to them the importance

[1] The male health extensions workers trained consisted of multipurpose workers (MPWs) and Community Development Officers (CDOs).

of men's role in women's reproductive health. The WCHP was started in 1996[2] to translate learning from the PID project into practice. Enhancing the public health system's outreach to men, with the aim of increasing men's responsibility in women's reproductive health, was one of the objectives of the project.

WCHP (also referred to as 'the project' in this chapter) was a collaboration of the Public Health Department of the MCGM, Society for Health Alternatives (SAHAJ), and Royal Tropical Institute (Amsterdam). The project focused on capacity building of municipal health care providers for providing gender-sensitive, quality reproductive health care services through the municipal primary health care facilities, namely the health posts and dispensaries. To increase men's involvement in women's reproductive health, the project focused on male multipurpose workers (male health workers), who are the only cadre of male outreach workers in the PHD of the MCGM.

This chapter draws on the information gathered over the duration of the project thorough exploratory research, documentation of various meetings and workshops with health care providers, and interactions with male health workers. At the onset of the project, baseline studies were carried out to understand health care providers' perspective towards women's health. The baseline study findings provided the basis for a number of workshops with grassroots health care providers, including male health care workers. Discussions during the workshops were documented and analysed to identify the key themes discussed, and the attitudes of the participants. A 'men's involvement committee' was formed after a series of workshops, exclusively comprising male health workers and their male supervisors. Participation in the committee was voluntary. Committee members discussed various issues around incorporation of gender-sensitive reproductive health into the

[2] Women Centred Health Project (1997-2002) was implemented as a pilot project in two of 24 administrative wards of the MCGM with a population of 1.2 million, as per Census 2001. Reaching out to men in the community was beyond the scope of the project with a small team of 15 persons. In view of the enormity of the population in the pilot areas, as well for ensuring sustainability of interventions beyond the project period, WCHP focussed on health care providers as change agents. Capacity building of health care providers was a major component of WCHP.

public health system, and developed a module for health and sexuality training of adolescent boys. All interactions with the male health workers–as participants in the research, workshops or as members of the committee–were documented in detail. Interviews with male health workers and male community development workers for the mid term and end of the project evaluation also provided information on male health workers' perspectives on the project's activities.

While the project designed activities to increase men's involvement in women's reproductive health, the team was careful to ensure that working with men should not result in women further losing control over their bodies or decision making. Even though the project conceptually recognised men's own reproductive health needs, for operational reasons, we defined 'men's involvement' as limited to their role as partners in women's health. The project provided male health workers with a more comprehensive understanding of the way notions of masculinity and male sexuality influence individual ideas, perceptions and behaviour. Through discussions, case studies and participants' experiences, the inter-linkages among gender, patriarchy, power and reproductive health were placed at the centre of all capacity building of the male providers.

Men's role in women's health: The broader picture

The feminist movement, and the International Conference on Population and Development (ICPD 1995) prioritised women's right to health and decision making about her body. In order to address the gender inequalities that undermine women's rights, the ICPD agreed that men should be encouraged and enabled to take responsibility for their sexual and reproductive behaviour, and to play a more active role in family planning and child-rearing. ICPD stated that changes in both men's and women's knowledge, attitudes and behaviour are necessary conditions for achieving a harmonious partnership of men and women (ICPD 1995).

Unequal power relations in the male-dominated Indian society affect all aspects of women's lives, including their sexual, reproductive and general health. Research in India shows that poor women carry a heavy burden of reproductive morbidity (Bang et al. 1989; Bhatia & Cleland 2001; Koenig et al. 1998);

a significant component of women's health which is unrelated to pregnancy and is due to reproductive tract infections and sexually transmitted infections (RTIs/STIs). As men's attitude and behaviour affect women's reproductive health (Piet-Pelon et al. 1999; Raju & Leonard 2000), unless men are involved, programme efforts will have limited impact (Pachauri 1999).

Research in the past decade demonstrates that involving men, by way of orienting them to the gender and sexuality aspects of women's reproductive health, positively affects women's reproductive health. *Pati Sampark* (literally, 'contacting the husband') programme in rural Gujarat in India showed that in the project area where men were contacted, women had a more in-depth understanding of antenatal care as compared to women whose husbands had not been included in the programme (Raju & Leonard 2000). Substantial evidence shows that involving partners in counselling for family planning, STI treatment, and HIV/AIDS testing and counselling is more effective than addressing women on their own (Kwaak van der A et al. 2007). Not only do programme managers want to involve men to improve the effectiveness of their programmes, but women also request that their husbands be contacted and sensitised about how their behaviour has a bearing on the reproductive health of their female partners (Raju & Leonard 2000; Khanna et al. 2002).

Paying attention to men's roles in sexual and reproductive health is important for gender equality and women's health, but also because men have a range of vulnerabilities and sexual and reproductive health needs of their own (Kimmel 1999). Socially prescribed gender roles and identities do not only give men power and privileges, but also make them vulnerable. Discussions with village men and youth in Gujarat revealed an unsuspected degree of vulnerability among men, leading to the observation that 'just as women need to liberate themselves from the stranglehold of patriarchy, men too need to free themselves from the patriarchal construct of masculinity' (Khanna et al. 2002).

In Bangladesh, 42 per cent of those who attended male health clinics complained of psychosocial problems like premature ejaculation, impotence and so on (Hawkes 1998). A study in Gadchiroli district, India, involving 600 males aged 15 to 44

years, found that 82 per cent suffered from reproductive and sexual complaints. They ranked these as the most serious complaints of males (Bang et al. 1996). Despite such high prevalence and perceived seriousness of male sexual and reproductive problems, 73 per cent did not receive any care for their complaints (NFHS 2001). Verma et al. hypothesise that men's sexual health problems adversely influence the quality of family life, discourage men from using contraception, and may result in domestic and sexual violence (Verma et al. 2000). Despite the emerging evidence about male sexual and reproductive health, and its links to gender relations and female sexual and reproductive health, provider biases often remain an obstacle in the promotion of male contraceptives (Helmer & Roitstein 1995).

Lessons From the WCHP Experience

The situation in the beginning…

Male multipurpose workers, along with their female counterparts (also known as auxiliary nurse midwife or ANM), are the first cadre of professionalised health care providers staffing the sub-centres in the rural health care delivery system, and the health posts in the MCGM's Public Health Department[3]. After high school, a male worker is given six months' training in public health. With virtually no scope of in-service training, low motivation, high absenteeism and over 60 per cent of the posts lying vacant, this cadre is the most neglected.

Male health workers in Mumbai are between 30 and 40 years of age, most have 12 years of formal education–that is, up to high school–with around 10 years of service in the MCGM. Most are from the lower middle class, and are married for more than five years. In the MCGM's Public Health Department, the male health workers occupy a low position. Placed at the most peripheral of the health care delivery centres (the health posts), male health workers share large part of their responsibilities

[3] PHD of MCGM has both male and female multipurpose workers. The number of female MPWs is very small and their duties are similar to those of the auxiliary nurse midwives. WCHP's work related to men's involvement in women's health was carried out with male multipurpose workers only. The term MPWs is used in this paper to refer to male multipurpose workers.

with auxiliary nurse midwives (ANMs), who are better trained in health issues as compared to the male workers. The ANMs and male health workers are supervised by a Public Health Nurse, a medical officer who is usually a female. Male health workers supervise female community health volunteers/workers. In the context of the MCGM's Public Health Department, male health workers' roles in reproductive health are limited to the promotion of vasectomies and distribution of condoms. In general, male health workers share with ANMs the responsibility of the implementation of various national health programmes, such as the Extended Programme for Immunisation, the Revised National Tuberculosis Control Programme, National Leprosy Elimination Programme and anaemia control programmes.

The project was aware that attitudes at work are an extension of attitudes in personal lives, and to influence work practices, it is important to understand the views health workers hold as 'persons'. Therefore, a series of exercises were carried out at the beginning of the project to understand male health workers' views on sexuality, on men's role in reproductive health, and on the role they saw for themselves in reaching men.

For example, male health workers were asked to complete sentences that would reflect their views about 'being a man'. The following responses show the concern of the male health workers about their own image as men:

Men cannot do: '*cooking and household chores*'.

Men are ashamed: *'if they are insulted by women (or if they lose face in front of women)', 'if they have RTIs/STIs', 'if women do their (men's) work'*, '*if they (men) have to cook*' or '*if they cry in presence of others'*

The same group believed that women want men to: *'look after them', 'understand them', 'cooperate with them in everything', 'to help in household chores'* and *'to be loyal to them'*

Interviews were conducted with men and women from the community (people who lived around the health posts and were users of municipal services) to explore the possible role male health workers could play in increasing men's involvement in women's reproductive health. Interviews with women who had experienced a reproductive health condition in the recent past and their husbands showed that one-third of the women (four of 14),

and more than half of the men (six of eight) interviewed were not provided with any information about the procedure(s) that the women underwent. All men interviewed for the study knew of their wives' health condition. However, they appeared to 'normalise' these problems as something that happens always or to all women–'…she had a severe backache, but it was normal and was cured after treatment'; '…delivery was caesarian and was normal'.

In another exercise, male health workers were asked whether they felt it necessary to increase men's involvement in women's reproductive health, and the role they saw for themselves in this regard. The responses show the internalised, gender stereotyped values of the male workers. They see the role of men in terms of the husband as 'benefactor', express the pressure men may feel in being providers, and see the role of women to serve their husbands. One MPW stated that he would like men to take the initiative in contraception–' ...women get married at a tender age and give birth to one child every year if the man does not take initiative'. Another reason cited for involving men was, 'when in good health, women can look after household duties'. One MPW opposed the idea of involving men in women's reproductive health, '...men work like bulls and it is not fair to them to expect them to look after all aspects of life'.

These statements highlight that the male health workers were responding from their perspective as partners and men, rather than approaching couples from a gender-sensitive health care provider perspective. This insensitivity towards the rights of clients is not limited to women but extended to some men from the community. One MPW reported motivating a man for acceptance of contraception 'if he belonged to socioeconomically weak household or was unemployed, or had addictions'.

Male health workers reported a number of obstacles in carrying out their primary role of motivating men for family planning. During interviews, the male health workers reported few opportunities for interacting with men, primarily because their work hours coincided with the work hours of most men from the community. Male workers tried to overcome this obstacle by talking to fathers accompanying children for immunisation, although this is not an ideal moment to talk with men about sexual and reproductive health issues. Some male

health workers felt that the attitude of men towards them limited their opportunities for working with men. According to male health workers, men either 'looked down upon them and made fun of them' or 'dismissed them and disregarded their advice regarding contraception'. In general, extension workers found men to be unresponsive and 'with closed minds' as far as advice for contraception was concerned.

Disseminating information regarding contraceptives to men was a key responsibility of male health workers. Their inability to do this successfully could be due to a variety of reasons, including possibly the non-receptive behaviour of male clients. In the period prior to WCHP interventions, male health workers did not receive training in communication regarding reproductive health, or on counselling men on use of contraceptives. Their low position in the clinical hierarchy, their own belief and value systems that were rooted in patriarchal notions about masculinity and importantly, and the lack of guidance on dealing with sensitive issues, resulted in male health workers' reluctance in approaching males about contraception use. We believe that this reluctance stemmed partly from their low self esteem, since after the sensitisation workshops about sexuality and masculinity, the WCHP counselling training, and with support from trained counsellors, many male health workers demonstrated improved counselling skills.

Interventions with male health workers

The project viewed health care providers as potential change agents. However, male health workers, as representatives of a highly male-dominant Indian society and as staff placed on the lower rungs of a hierarchical clinical system, felt threatened by the approach of the project. In the initial phases, male health workers resisted the training programmes. Fear of an 'additional burden of work' was the reason given for refusing to participate in the workshops. Male health workers also accused the health system of ignoring health needs of men in the community, and the project team of continually reinforcing the 'women centred' perspective and thereby excluding men.

To accommodate the feelings of insecurity, develop the self esteem of the male extension workers and show trust in their capacity, the project emphasised the importance of their ideas

and observations. The training programmes were aimed at reflection and transformation on their role as individual men, as sons, husbands and fathers, and as health care providers.

Five workshops were designed to combine theoretical aspects with practical skills. A total of 33 male health workers participated in the workshops. The content of the training workshops were later documented in a training manual[4]. Through the exercises during the workshops, pre-post tests and informal interactions following the workshops, the project team developed an understanding about key factors in value clarification and transformation of male workers in relation to sexual and reproductive health. The experience provided lessons regarding the methodologies that could be used for working with male health workers.

The initial resistance to the training programmes subsided when two medical doctors and two male facilitators with field experience of community organising and of imparting health education to men were invited as resource persons. These trainers were excellent role models as gender-sensitive men. It was observed that the male health workers could identify with their experiences and were more engaged in discussions.

Different exercises were required for discussing issues around gender and health with men and women health workers. While with women health workers, personal experience sharing was a good starting point in training on gender and health, arguments supported by evidence - statistical or in the form of experiences from other parts of the country and the world - were more acceptable to the male health workers. Male health workers were open for group work and discussion after the rationale was provided based on evidence.

In the initial phases, male health workers objected to role-plays used in the workshops. In a later phase, exercises such as 'power walk'[5] , group work on 'effects of patriarchy on men and

[4] See 'Working with Men: Gender, Rights, Sexuality and Health–Trainers' Manual' published by SAHAJ, Baroda, 2005

[5] Power walk is a simulation exercise designed to get participants to identify various basis of power linked to identities and to experience feelings of powerlessness associated with identities such as an old man without resources for survival, a young woman with a low salary job, a youngest brother in a highly patriarchal joint family etc.

women', and discussion on contents and messages given through 'non-veg' jokes[6] were useful in initiating discussions with male health workers. Films were also effective in initiating dialogue.

Examining views on gender relations

The starting point of the process of understanding gender was a critical reflection on commonly held views, facilitated by male facilitators. In a discussion based on case studies from other parts of the country, extension workers would agree that women bore a higher burden of chores, that this was shaped by the traditional male-dominated society, and that men should share responsibilities related to house-keeping and child-rearing. But when it came to discussing their own role at home, or the role of men in the communities they worked with, they turned to generalising the context rather than examining their own home situation: 'In Mumbai, both men and women earn and men help at home; the situation in backward areas of the country really needs some improvement'.

In the first workshop on gender and health, following a discussion on violence as a gender and health issue, the participants tried to justify domestic violence. They argued that violence against men is common but unspoken: 'Violence against men is different and hidden. If a woman does not cook and serve her husband properly, it is violence against him'. This example shows that male health workers' perception of violence against men is based on existing gender stereotypes, and as discussed by the facilitators, the notion of women not cooking as an act of violence against men arises out of the societal norms of a patriarchal society. Participants were provided the space to share their own experiences of violence against them. On examination, the group could not come up with one genuine example (experienced by the participants) of victimisation of men by women. Later, this discussion was used to contextualise the gendered nature of violence against women.

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[6] The term 'non-veg' jokes refers to sexual jokes which, in this context often consisted of indecent innuendos about women's reproductive organs. The facilitators discussed these to bring forth the male health workers' attitude to trivialise women's reproductive health and men's insecurities reflected in absence of any light-hearted reference to male reproductive organs.

Outcome of the gender sensitisation efforts of WCHP

Interventions by WCHP influenced male health workers in two important ways – first, the inputs helped them change/revise their understanding about gender and men; and secondly, they clearly saw a role for themselves in discussing gender, sexuality and health with their male clients.

Male health workers expressed their changed understanding through a number of ways. For example, following the initial workshops on sexuality and reproductive health, 11 out of the 33 male health workers volunteered to be part of a 'men's involvement committee' to discuss the potential role of male workers in the Reproductive and Child Health Programme of the Government of India, and strategies for men's involvement in reproductive health in institutional settings. The committee met regularly for three years. Over time, it became a forum for discussing problems related to implementation of their gender and sexuality related learning. Further training needs were identified and ideas related to masculinity and reproductive health were discussed in the meetings of the committee. Male health workers from the non-project areas were attracted by these discussions and the group became larger. The committee evolved into a 'space' for male workers to explore new expressions of masculinity.

The changed views were also apparent in the male health workers' documentation of their experiences of the learning process and exposure to concepts like gender, sexuality and patriarchy. Some of these reflections were converted into articles and published in a periodic newsletter brought out by the project. Reflecting on a particular workshop, one participant wrote, 'The session on "Trust" gave me experiences that will remain with me forever.' Another write-up was about an animated discussion following the screening of a feature film 'Astitva'. This film depicts the double standards around male sexuality that exist in society.

In another informal discussion, following the gender and health workshop where violence as a gender issue was discussed, one MPW said that before the workshop, he believed that some women get raped because they bring it upon themselves; but after participating in the workshop discussions, he began to carefully examine the reports in the newspapers. He said he

realised that in most cases, the woman is powerless—she is either too young or too old, or in an environment unfamiliar to her, or is raped by men she trusts. This understanding is still a far cry from accepting that there is never an excuse for violating another person's body, but a step in that direction nonetheless.

Self perceived changes in views around gender, sexuality and health were apparent in the discussions and interviews carried out as part of the end-of-the-project evaluation. Two male providers expressed that their participation in a workshop on communicating about sexuality in the community (Stepping Stones Workshop) resulted in changes in their relationships with their wives. Communication between couples increased, as did their sensitivity to their partners' needs (including sexual needs), and they started giving them increased emotional support - 'I became more sensitive to my family's, including my children's, perception of me'. These personal changes were reflected in their work as key trainers. One of them shared how he felt safe enough to speak of his own dilemmas in the training that he conducted. He could share his own experiences of bringing about changes in his own relationships. This confidence in turn helped dissolve the inhibitions of the trainees.

In focus group discussions during the project evaluation, male health workers reported that they realised the role that they can play towards gender equality. They said that the training workshops had taught them that women are not weak. Through the workshops they realised that men and women are equally constrained and trapped by traditional role prescriptions–'*Stree bhi peedit hai, purush bhi peedit hai* (Women are affected (by the system) and men are affected too!)'. Men have the pressure to be 'masculine'–'they cannot cry or express their emotions because they would be labelled *baaylaa* (effeminate)'. They could begin to apply their gender understanding to the client-provider relationship and women's health. 'Doctors have a medical opinion about pregnancy and the possibility of sexual relations during pregnancy. But women's feelings about this must be acknowledged. It is not sufficient to go only by a clinical opinion.' (WCHP 2005)

Subsequent to the training workshops, male health workers saw an important role for themselves in providing information

to men. They said that they could talk to men and 'help them understand women's perspective', and believed that providing information on abortion and contraception to men waiting at a hospital outpatient department, and development of information, communication and education material for men on these issues, could be good entry points for male health workers to initiate work with men. Acting on this suggestion, the project provided training in counselling to some of the male health workers, who successfully provided information and counselling to 180 men who accompanied their partners to the gynaecology clinic in a secondary hospital[7]. Some male health workers successfully carried out health education sessions on reproductive tract infections for men in the community, although they reported having problems contacting men during their own working hours as the men were also away on work. Some formed groups of adolescent boys and held health education sessions, which were more successful.

Through their extensive interactions with men during the counselling sessions, and in the course of group health education sessions, male health workers gained insights into the specific health needs of men. They reported that men prefer male doctors, and providing clinics with male doctors that ensure privacy and confidentiality is necessary to encourage men to seek reproductive and sexual health services.

A male health worker shared how he became more client-centred after the training. His counselling of the hotel boys who visited sex workers improved, and, as a result, the hotel boys, a closed group, became more open. He reported that there was a reduction in the number of boys who went back to sex workers.

Although initially resisting discussions on gender and sexuality, male health workers later took the lead in developing a health education module for adolescent boys that would discuss the very same topics. Four male workers volunteered to develop a manual on sexual and reproductive health to sensitise out-of-school adolescent boys on gender, sexuality, and reproductive

[7] Between 2000 and 2006, the WCHP ran a counselling centre within the Gynaecology Clinic at the VN Desai Hospital, a secondary hospital of the Municipal Corporation. Between January 2001 and December 2002, MPWs counselled 180 men accompanying their partners to the gynae clinic.

and sexual health. Convinced that gender and sexuality are essential components of health education, male health workers suggested a variety of exercises to be used with adolescent boys. They asked for reading material and did a self-study, and developed various modules. Subsequently, they presented the draft manual to a group of experts for feedback. During a discussion on whether a separate module should be developed on gender, one MPW repeatedly stressed the need to discuss gender aspects for each of the topics included in the manual, such as nutrition, physical exercise and games, sexuality etc.

As mentioned earlier, working with male health workers was an uphill task, and the project succeeded in getting a foothold only after many trials and errors. The activities involving male health workers gained momentum in the last two years of the project. Though documentation was maintained, the period was too short to demonstrate any quantitatively measurable impact on the work of the male health workers. However, a review of contents of counselling to men (usually partners of women seeking services at a gynaecology outpatient department at a secondary hospital) showed that the trained male health workers provided men clients with information on the women's health status, possible roles the men partners could play (e.g. 'she needs rest'/ 'you must make sure that she gets some rest for a few days'/ 'she is weak, her body needs nutrition, you should take care that she eats well' etc) and addressed any queries their male clients asked. It was also noticed that with a male counsellor at the counselling centre, many men came in to ask questions related to their own health as well.

Discussion

There is growing acceptance of the involvement of men as partners in women's sexual and reproductive health, and for their own sexual and reproductive health needs as well. Strategies for working with men in diferent contexts are being experimented with. This chapter presented an example of what it takes to address men as gendered and sexual beings. Gender sensitisation of male health workers was a difficult process–for male halth workers because they had to re-examine their views and position in a male-dominated society, and for the project

because suitable methodologies had to be identified. The training workshops did not result in a complete change in the views and practices of male health workers. Nor was this expected. The workshops and discussions did, however, start a process wherein male health workers began reflecting on the systemic nature of how gender operates, how their masculinities are constructed, and the effects of gender issues on reproductive and sexual health, The men's involvement committee' and the module preparation committee' that met at least once a month, provided the necessary space for male health workers to carry the discussions further.

The workshops and training sessions organised by WCHP served a purpose beyound the intended one of imparting knowledge and skills to enable male health workers to discuss gender, sexuality and health during their work. The workshops organised for them by 'workplace trust', as conceptualised by Gilson et al,. resulted in their taking initiative as health care providers and an improvement in 'patient-provider trust' (Gilson et. 2005).

The experience of working with male health workers also highlights that issues related to sexuality cannot be incorporated into health care provision, unless health providers are sufficiently enabled to talk about these issues. The inadequacies and low self esteem of male health workers were addressed by providing them with the necessary information, and the non-judgemental space to explore theri internalised notions of male and female sexuality, as well as communication and counselling skills to takl about sexuality and sexual health issues with men and women in the community. Value clarification around their own masculinities and sexualities was an important part of their transformation. Similar experiences have been reported in the context of integrating HIV/STD prevention with family planning by International Planned Parenthood (Helmer; Roitstein 1995). These kinds of approaches represent a move away from a top-down biomedical approach to a rights-based, gender-sensitive approach. Transformatory training processes, as suggested in this chapter, take time, and resources to support them have to be budgeted for.

The multi-pronged approach employed by the WCHP involved boosting male health workers, self esteem, encouraging them

to re-examine their role in reproductive and sexual health services, providing them with skills and knowledge to fulfill these responsibilities, and creating spaces for them to employ the skill and to share their experiences. This proved useful in effectively reaching out to what is commonly perceived as a problematic cadre of helaht providers in India. Career advancement opportunities, and professional and personal development may work as motivators and help transform this cadre of health providers, into productive agents of change. The WCHP experience clearly demonstrated that male health providers can be trained on gender, sexuality, rights and health through appropriate methodologies. What is important is that the male providers should feel valued as human beings and realise that they have the potential to be effective change agents for transformative masculinities.

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