IJHDIS: Vol. 12, No. 1 (January-June 2019) pp. 1-15 ISSN : 0974-3529

FACTORS RESPONSIBLE FOR UNEQUAL BURDEN OF FAMILY PLANNING METHODS ON WOMEN IN INDIA

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Abstract: *It is well recognized that improvement in the health status of population is both an important means of increasing productivity and economic growth as well as an end in itself. The importance of improvements in health is also acknowledged in the Millennium Development Goals of the UNDP, which calls for a dramatic reduction in poverty and improvements in health, especially of the poor. The SDGs have further highlighted the importance of health. The decadal growth of population is more than the population of Brazil. India was the first country to launch family planning programmes in 1952 and then kept on changing strategies in relation to international conferences like that of Mexico, Cairo, Beijing etc. with limited success. India's demographic parameters, future fertility transition and population stabilization would primarily depend on the changes that may occur in the four large states viz. Uttar Pradesh, Bihar, Madhya Pradesh and Rajasthan accounting for about 40 percent of the country's population. There has been unequal burden of family planning on women as there has been shifting of focus from men to women. Against this backdrop, present paper purports to examine the factors responsible for increased use of family planning methods by women.*

INTRODUCTION

Despite a long history, spanning some five decades, India's family planning programme has not yet achieved replacement level fertility. Efforts are, therefore, currently underway to reconceptualise the programme to design and implement priority strategies for achieving programmatic goals. Couples in India have a significant unmet need for both limiting family size and spacing births. Yet, the national

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programme has not, so far, been successful in providing them with a choice of contraceptive methods. To translate the fundamental concept of informed contraceptive choice, it is imperative that the quality of services is improved. Context-specific, targeted strategies are needed to provide method choice to enable clients to achieve their reproductive goals. There is an urgent need to address the problem of high unmet contraceptive need among young couples especially among married adolescents. The pace of decline in both fertility and mortality has been slower. It is, therefore, important to focus efforts and resources in these states. Integrated programmes that can more effectively and efficiently address multiple reproductive health needs of the people should be implemented. Such integrated programmes must necessarily be designed using a gender lens as in India's patriarchal society son preference remains strong. Son preference results in larger families as couples try to achieve their desired family composition. Several promising contraceptive technologies are currently in the pipeline. But for these technologies to be effectively delivered by service providers and accepted by clients, it is important that scientists developing technologies collaborate with professionals engaged with planning and implementing programmes and for all stakeholders to understand the needs and perspectives of the end-users of these technologies.

REVIEW OF LITERATURE:

Review of literature is important to examine the grey areas of research and find out the research gaps which may be bridged through study. Since long, international family planning and reproductive health programmes focussed exclusively on women (Greene 1998). As a consequence, population policies were implemented almost exclusively through basic family planning programmes serving women. Amatya et al. (1994) opined that men were involved in family planning in a limited way due to non - acceptability or to promote the diagnosis and treatment of sexually transmitted infections (Mbizvo et al. 1996). Although both men and women have responsibilities and interest in reproductive health and family planning, demographic studies on fertility and family planning have overwhelmingly focused on women. (Berer, 1996, Greene and Biddlecom, 2000).

In practice, the effect that men have on their own and on women's reproductive lives may be more varied. To exclude men from information, counselling, and services is to ignore the important role men's behaviour and attitudes may play in couples' reproductive health choices (Bloom et al. 2000). In some countries, societal norms, religious practices, and even legal requirements provide men great influence over decisions that affect their family's reproductive health. Ringheim (2002) is of the view that many women and their partners would like to participate in reproductive health counselling and services around the globe. In response to these factors, programmes are increasingly seeking ways to develop strategies that allow men's constructive involvement in family planning and other reproductive health services. Studying male involvement, therefore, is important to understand the multiplicity of forces shaping reproductive decisions among women and men (Clark et al. 2008). The involvement of male in family planning has been found critically dependent on addressing the social and cultural norms which hamper health (Benstein and Hansen 2006, Greene et al. 2006, Pande et al. 2006). It is very difficult for men to access accurate, timely and good quality reproductive and sexual health information and services (Pande et al. 2006). The programme to involve men in reproductive health uses many terms, including men's participation, men's responsibility, male motivation, and male involvement, men as partners, and men and reproductive health (Danforth and Jezowski 1997, Finger et al. 1998, Helzner 1996b, Verme et al. 1996). However, there is no consensus about which term best describes this perspective on men, what these terms mean, and how men can best be involved in reproductive health activities (Danforth et al. 1994, Danforth and Roberts 1997, Verme et al. 1996).

OBJECTIVES AND METHODS

Present paper aims to examine the factors responsible for increased use of family planning methods by women in India. The paper is based on mainly secondary data and pertinent literature , however, inferences, and conclusions based on a major research study conducted recently by Pt. G. B. Pant Institute of Studies, in Rural Development, Lucknow , have been used in the paper. The study was conducted in five states of India, viz. Uttar Pradesh, Rajasthan,

Bihar, Madhya Pradesh and Chhattisgarh, covering a sample of 1500 women. The survey was conducted with the help of structured interview schedule.

CRITICAL APPRECIATION OF POLICY

The national population policies could no yield the desired results and India remains one of the world's second largest populated countries . The population of India in 1951 was 35 crore, but in 2011, it had increased to 121 crore. There have been few shortcomings. Firstly, the national population policies have a narrow perspective; give much importance to contraception and sterilisation. The basic prerequisite of meaningfully controlling population includes poverty alleviation, improving the standards of living and spread of education. Secondly on national scale the policy was not publicized and failed to generate mass support in favour of population control. Thirdly, due to insufficient health infrastructure , lack of trained staff, lack of motivation among health staff and limited use of the equipments for population control resulted in the failure of the health and population policy. Lastly, the use of forced sterilisation during the Emergency period (1976-77) has caused a serious resentment among the masses. This made the very National Population Policy itself very unpopular. Lack of sufficient priority for the Family Planning Programme was most severe problem in the states. This insufficient feeling of urgency was hindering the development and implementation of the programme in many ways. It was observed that State Family Planning Boards had not always been very effective. In the State Family Planning Bureaus, the sanctioned staffing pattern was inadequate to carry out the leadership and executive functions. Moreover, district family planning committees had not lived up to their potential for providing support to the programme. Transportation was reported to be a severe and crippling bottleneck in every state family planning programme, since it was needed for supervisory purposes, for mobile sterilisation or IUCD services, for mass publicity purposes. Public health services are being provided free of cost or with nominal fee. Health care service in rural areas is being provided through a network of public health centers, ranging from Sub-Centre at the village level to Primary Health Centers at

block level, Community Health Centers at sub district level and District Hospital at district level. All public health and family welfare services including abortion are being provided through this network of health centers, with specializations varying with the level of facility. However, urban areas do not have a well-defined hierarchy of public health centers. There is high concentration of tertiary level health centers including district hospitals , medical college and other private super specialised health centres . Other than public health centers, India has a robust private health sector, ranging from single physician clinics to large multispecialty hospitals, with tertiary level facilities generally concentrated in large urban centers. Institutional deliveries in public health centres are incentivized through conditional cash transfer scheme called the Janani Suraksha Yojana .The success of JSY has led to a rise in institutional deliveries from 47 percent in 2007–08 to 73 percent in 2010 as per latest available estimates. The quality of health care has emerged as a key concern particularly in the context of increased uses of facilities for maternity services. The family welfare services are focusing on counseling and birth control. Governed by separate Act, induced abortion (or medical termination of pregnancy) in India is legal, but can be provided only in licensed facilities, and only by trained personnel. Over the years diverse actors have contributed to the policy making process, from the judiciary to Government, senior experts, academicians, activists and development partners. Government, under the NRHM, made provisions for creating a number of multi-stakeholder task groups on different themes which helped in developing various strategies. The diversity in involvement of various stakeholders in health care services has ensured significant changes and shifting from the traditional top-down approach of health service provision towards a more decentralized way with greater flexibility to the states. The community based monitoring of services, constitution of participatory patient welfare committees and creation of untied funds to provide facilities for discretionary spending as per need were introduced in the first time in India. According to the latest data, the total number of family planning acceptors in India decreased by 0.16 percent between 2015-16 and 2016-17. It has been observed that condom is the most preferred

method of family planning while sterilization is the least adopted means. The number of couples adopting various family planning methods during 2016-17 was reported to be 25.5 million and out of them 10.1 million couples preferred condoms. The total number of family planning acceptors in India has shown a gradual decreasing trend after 2007-08. About 3.94 million people underwent sterilization during 2016-17. The number of sterilization has decreased by 2.08 lakhs (5.0 percent) in 2016-17 as compared to 2015-16. Of the total sterilizations conducted, vasectomy (male sterilization) comprised only 1.9 percent .Of the total number of sterilisations, Andaman & Nicobar had the highest percentage of vasectomies (30.5 percent) in 2016-17 while no vasectomy has been reported in the state/ UT of Mizoram and Lakshadweep (Govt. of India, 2017). The number of vasectomies carried out in almost all bigger states is quite insignificant as compared to number of tubectomies . Of the total tubectomy operations carried out in the country, 36.4 percent reported accounts for Laparoscopic tubectomies during 2016-17. Laparoscopic Tubectomies are more prominent in Himachal Pradesh (87.5 percent) followed by Madhya Pradesh (84 percent), Rajasthan (79.7 percent), Tripura(73.7 percent), Assam (71.7 percent), Uttar Pradesh (69.3 percent), Uttarakhand (61 percent), Nagaland (58.8 percent), Delhi (57.8 percent), Jammu & Kashmir (57.8 percent), Daman & Diu (53.6 percent) and Dadra & Nagar Haveli (52.3 percent). At the national level, the number of IUD insertions during 2016- 17 showed an increase of 7.76 percent as compared to 2015-16. The bigger States showing increase in performance during 2016-17 are Andhra Pradesh, Assam, Chhattisgarh, Gujarat, Jharkhand, Maharashtra, Odisha, Rajasthan, Jammu & Kashmir, Uttar Pradesh and West Bengal while usage has gone down in Bihar, Haryana, Karnataka, Kerala, Madhya Pradesh, Punjab, Tamil Nadu and Telangana. According to the available data, the number of equivalent condom users increased marginally from 4.42 million in 2015-16 to 4.57 million in 2016-17 under free distribution scheme but under Social Marketing Scheme, it has decreased from 6.5 million in 2015-16 to 5.6 million in 2016-17. Overall, the condom users have decreased from 10.9 million in 2015-16 to 10.1 million in 2016-17.

The increase in condom users under free distribution during

2016-17 has been observed in 9 major states viz. Andhra Pradesh, Assam, Bihar, Gujarat, Haryana, Karnataka, Kerala, Odisha, Tamil Nadu, Telangana and West Bengal as compared to 2015-16. The significant observation is that the number of takers of free condoms increased by 3.4 percent in 2016-17 as compared to previous year whereas in 2015-16. However, the number of users has decreased in the case of Social Marketing Scheme. During the year 2016-17, 3.47 million oral pill users were worked out under free distribution scheme as against 3.3 million in 2015-16. Among major States, Andhra Pradesh, Assam, Gujarat, Haryana, Jharkhand, Karnataka, Kerala, Maharashtra, Punjab, Tamil Nadu, Telangana, Uttar Pradesh and West Bengal have reported increased number of oral pill users in 2016-17 as compared to 2015-16 under free distribution scheme while in respect of other major States, there was drop in the number of users. Under social marketing scheme, the oral pill users have also improved and increased from 1.65 million in 2015-16 to 1.99 million oral pill users during 2016-17. Overall, the oral pill users increased from 4.97 million in 2015- 16 to 5.45 million during 2016-17.

Female sterilization is still one of the most popular modern contraceptive methods in India . As per NFHS IV ,2015-16 , among currently married women age 15-49, 36 percent use female sterilization, followed by male condoms (6 percent) and pills (4 percent). Six percent use a traditional method, mostly the rhythm method. Among sexually active unmarried women, female sterilization is the most commonly used method (19 percent), followed by male condoms (12 percent). The contraceptive prevalence rate among currently married women age 15-49 decreased slightly, from 56 percent in 2005-06 to 54 percent in 2015-16 . Use of contraceptive methods is the lowest in Manipur, Bihar, and Meghalaya (24 percent) and the highest in Punjab (76 percent). Among the states, a relatively low proportion of currently married women use contraceptive methods in all of the smaller states in the northeast region except for Sikkim and Tripura, as well as Goa. Among the union territories, the use of contraceptive methods is the lowest in Lakshadweep (30 percent) and the highest in Chandigarh (74 percent). Almost seven in 10 (69 percent) modern method contraceptive users obtained their method from the public health sector. The rest of the users of modern methods

obtained their method from the private health sector including NGO or trust hospitals/clinics (24 percent) and other sources (6 percent), including shops, their husband, friends, and relatives. A lower proportion of ,urban users (58 percent) than rural users (76 percent) obtained their method from the public health sector. The public health sector is the major source of female and male sterilization and IUDs/PPIUDs, whereas the private health sector is the major source of pills, injectables, and condoms/*Nirodhs.* Two-thirds of currently married women age 15-49 have a demand for family planning; 11 percent want to space births, and 55 percent want to limit births. As per report of NFHS, 2015-16 , 54 percent of currently married women are already using a contraceptive method either to space or to limit births, and therefore have their need met. However, 13 percent of currently married women have an unmet need for family planning, including 6 percent who have an unmet need for spacing births and 7 percent who have an unmet need for limiting births. It is expected that even If all currently married women who intend to limit their children use family planning method, the contraceptive prevalence rate would increase from 54 percent to 66 percent. The total demand for family planning among currently married women age 15-49 in India decreased slightly from 70 percent in 2005-06 to 66 percent in 2015-16. The unmet need for family planning was almost the same in NFHS-3 and NFHS-4 (IIPS, 2016).

Review of family planning policies and programmes show that in recent years India has developed a comprehensive set of guidelines and strategies that are driving quality assurance and improvement in Maternal New Born Health Family Planning + Adolescent services in the country. NRHM and RCH II for the first time laid out a long-term vision of improving quality, access, coverage, and assuring service availability and effectiveness. It has bben observed that India has quality policy guidelines and operational strategies relating to use of infrastructure and commodities, human resources management , however, accountability and transparency is lacking. Besides, strong regulatory framework has also been designed to monitor quality of health care service both in the government and the private sector, however, personalized health care and maintaining patient privacy, as well as grievance redress mechanism could not placed. Aspects

such as promptness of health care, information sharing and good behaviour of health personnel need to be incorporated in the current policies.

Family Planning 2020 is a global movement which encourages women and girls to decide for themselves to have children . Launched at the 2012 London Summit on Family Planning, Family Planning 2020 aims to enable 120 million additional women and girls in the world's lowest income countries to use voluntary modern contraception. More than 125 partners, donor agencies , foundations, civil society organizations, multilateral institutions, and private sector partners have joined hands with Family Planning 2020 with commitments to support, expand, and fund rights-based family planning methods . India's Family Planning 2020 goals aim to drive access, choice, and quality of family planning services. In order to achieve the Family Planning 2020 targets, India has made its sincere efforts to expand the range and outreach of contraceptive options through introducing new contraceptives and delivering a full range of family planning services at all levels. India has integrated family planning into the Reproductive, Maternal, Newborn, Child, and Adolescent Health (RMNCH+A) Strategy. The Government of India has enhanced its supply chain system through rolling out Family Planning Logistics Management Information System (FP-LMIS). There is high priority on Increasing awareness and generating demand for family planning services through comprehensive media campaigns. The Government of India has also augmented the financial investment on family planning. At the 2012 Summit, India committed to spend USD$2 billion by 2020 for family planning program and, in July 2017, India renewed its commitment to invest USD$3 billion by 2020.

There are gaps in quality of health care which affect utilization of health facilities. The conditional cash transfer approach to increase institutional deliveries has not resulted to reduce maternal mortality.. The net money transfer was also not appreciable. There is need for considering emotional and psychological aspects of women delivering in hospitals while incentivizing birth outcomes. Person-centered health care is required . The Government of India has expanded its scope of quality monitoring to cover MCH services at facilities, including assessing the quality of training provided to staff,

and has increased the overall financial commitment for it . There is need of imphasis on training and skill building in the guidelines i to ensure appropriate clinical health care. Training should also incorporate aspects of the person- centered care like interpersonal behaviour, information sharing, ensuring privacy and appropriate counselling. The currently quality improvement initiatives do not regularly assess patient satisfaction with services or disrespectful and abusive behaviour of service providers. Community feedback and monitoring mechanisms, is important to improve efficiency in health care facilities. In public hospitals where NRHM has successfully addressed infrastructural issues, it is need of hour to focus on patient centered health care. Thus, while policy needs to be strengthened on some aspects of patient-centered care, at the same time existing gaps in quality of health care need to be addressed in order to create an conducive environment for achieving patient-centered health care.

FACTORS RESPONSIBLE FOR UNEQUAL BURDEN

There are several reasons for shifting of focus of family planning from men to women . Lack of choices of contraceptives, women centric schemes of government, men being the main decision makers and lack of male health personnel among the frontline workers are some of the factors. There are socio- cultural and economic factors responsible for increased use of family planning by women. These mainly include lack of choices for men, women centric awareness campaign, target based approach of family planning, the concept that women should bear the responsibility of family planning as men are the bread earners, and even women do not want to involve their spouse in the use of permanent family planning thinking that it may harm their health. However, more than half of the respondents reported that their spouse allow health workers to provide counselling services to them. Limited options in the basket of choice for men, lack of awareness activities, lack of government efforts in promoting male involvement and men consider use of contraceptives as women's job were some of the main factors responsible for lack of male involvement in family planning.

The value of chi square test found between age of respondent and decision making in family found 149.44 which is highly significant.

Its mean age is highly associated with decision making in family. The value of chi square test found between caste and partner's feeling that equally responsible for family planning is found 53.47 is found highly significant. Its mean caste system is matter feeling of partner for responsible for family planning. The value of chi square test between educational level of respondent and awareness about family planning has been obtained 87.130 which is highly significant. Its means the education level of respondents is associated with awareness about family planning. The value of chi square test between education and source of information about family planning i.e. media and ASHA, Anganwadi worker (having more than 50 percent has been found 105.36 and 24.55 which are found highly significant. Its mean the highly obtained frequency of source of information have highly associated with education of respondents. The value of chi square test between caste and spouse's willingness to adopt permanent method of contraception on behalf of wife has been found 28.57 which is found highly significant. Its mean the caste system is highly associated with spouse's willingness to adopt permanent method of contraception on behalf of wife. The value of chi square between caste and perception on use of contraceptives reducing infant and maternal deaths has been found 11.11 which is found significant. Its means caste system is moderately associated with perception on use of contraceptives reducing infant and maternal deaths.

The value of chi square test between education level and preference of family planning methods has been found 18.98 which is highly significant. Its means the education level is highly associated with preference of family planning methods. The values of chi square test between caste and each reasons responsible for the shift of focus of family planning from men to women have been found 286.84, 37.44, 100.81, 2.66, 12.75, 84.84 and 16.13 which are found highly significant except only lack of choices of contraception for males reason. Its means caste system is highly associated for the reasons responsible for the shift of focus of family planning from men to women except lack of choices of contraception for the males.

The correlation between independent variables i.e. caste, religion, occupation of respondent, annual family income, age of respondents and education level; and awareness score (sum of scores obtained

for each schemes) has been computed. Table 6.22(a) shows that awareness of family planning schemes implemented by state and central government is found highly positively correlated with annual family income and education. While caste, occupation of respondent and age of respondents showing highly negatively correlated with awareness of family planning. The awareness of family planning also found significantly negatively correlated with religion. The correlation coefficient between education and people participating in discussion on family planning (sum of scores) has been found highly positively significant (0.29 at 1% level of significance). The correlation coefficient between caste of respondent and social reasons for burden of family planning methods by women in society (sum of scores) has been found highly negative (-0.30 at 1% level of significance).

Table 1

Correlation Coefficient Between Independent Variables And Awareness Of Family Planning Schemes

Independent variables	Awareness of Family Planning Schemes of State and Central Governments
Caste	-0.497**
Religion	-0.051*
Occupation of Respondent	-0.154**
Annual family income	0.390**
Age of Respondents	-0.110**
Educational Level	0.083**

**. Correlation is significant at the 0.01 level
*. Correlation is significant at the 0.05 level

CONCLUSION

The analysis simply demonstrates that main decision makers in the family are male members and head of the family. However, they were of the view that their spouse is equally responsible for family planning. A significant proportion of respondents admitted that their spouse is willing to adopt permanent family planning method on behalf of them. Most of the respondents were fond preferring temporary family planning methods. There are several reasons for

shifting of focus of family planning from men to women. There is need to increase the number of male front line workers who can provide counseling and family planning services to the target population. It is suggested that a male cadre of front line workers may created for targeting male population to provide counseling and health care services including family planning services. There is need to discourage the target base approach of family planning. The target base approach of family planning should be shifted towards self motivated acceptability of family planning methods. Similarly, the incentives for adopting permanent family planning methods by women should be discouraged while there should be higher incentives for male sterilization.There is need to strengthen the supply chain network of contraceptives particularly, male contraceptives. The involvement of community based organizations and NGOs should be increased in family planning services to mobilize the community for adopting permanent family planning methods by men.

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