

Involving Men in Reproductive Health in Bangladesh: Issues and Challenges

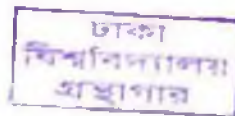
**A Thesis Submitted to the Department of Statistics, University of
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Masters of Philosophy at University of Dhaka**

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By

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Men's Participation in Reproductive Health Care:

Men's participation in reproductive health can be defined as the actions men take to enable their wives to use contraceptive methods. One enabling mechanism is the discussion about family planning with their wives. Men can also support their wives by approving F.P. again men can support their wives by taking care of their reproductive health care (include those respondents who think that women should have a medical check-up when they are pregnant even they are not sick or present during the antenatal care visit or talked with wife about own/baby's health or present at the time of birth or took child to the health facility for immunization).

Men's Knowledge and Awareness about AIDS and STDs:

One of the most important strategies for reducing the risk of HIV/AIDS and other STDs infection is the promotion of accurate knowledge of HIV/AIDS and STDs, how it is transmitted and how to prevent transmission. Finally, our concern is to know men's knowledge about HIV/AIDS and STDs and also about ways to avoid these diseases.

Independent variables

In this study the terms, 'husbands', 'men', 'respondents' and 'males' will be used interchangeably which include currently married male respondents. To investigate the male involvements in family planning in Bangladesh, we deal with a large number of explanatory variables; some of the variables are found to be important from demographic point of view while others are from socio-economic point of view. Generally the following independent variables are used.

1. Age of the respondents.
2. Education of the respondents.
3. Occupation of the respondents.
4. Division.
5. Place of residence.
6. Religion.

7. Number of living children.
8. Ideal number of children.
9. Ideal number of sons.
10. Child loss experience.
11. Respondents approve FP.
12. Discuss FP with partner.
13. Exposure to mass media

To meet the objective of the study many composite index and new variables are also created.

2.4 Analytical Technique

The present study is based on mainly 2,249 matched couples. The matched sample obtained through matching 10,544 ever-married women aged 10-49 and 2556 currently married men aged 15-59. The married men interviewed in the BDHS survey were selected from a sub sample of households in which ever-married women were interviewed, it is possible to match male respondents with their wives to obtain a data set match couples. Information on knowledge and use of contraception and fertility behavior was gathered on the basis of both husband's and wife's reports. In the study, bi-variate analysis is carried out. Multivariate analysis is applied to assess the net effects of the independent variables.

Bi-variate Analysis

In case of bi-variate analysis, which examines the independent variables individually, that gives only a preliminary notion of how important each variable is by itself. The examination of percentages in a by-variate analysis is a useful first step in studying the relationship between two variables, these percentages do not allow for qualification or testing that relationship. For these purposes, it is useful to consider various indexes that measure the extent of association as well as statistical test of the hypothesis that there is no association. Chi square test of independence is performed to test the existence of interrelationship among the categories of two qualitative

variables. In this study, some of independent variables are quantitative. In order to perform differential analysis, it is required to make these variables into categorical variables by differentiating each quantitative variable into various categories. All these analysis have been done through bi-variate analysis.

Multivariate Analysis

An interesting method that does not require any distributional assumptions concerning explanatory variables is Cox's linear logistic model (1970). The logistic regression model can be used not only in identifying the risk factor but also to predict the probability of success. The model is now widely used in research situation to assess the influence of various socioeconomic characteristics controlling for the effect of other variables on the likelihood of the occurrence of the event of interest. Logistic regression model is useful for situations in which we want to be able to predict the presence or absence of a characteristic or outcome based on values of a set of predictor variables.

It is similar to a linear regression model but is suited to models where the dependent variable is a dichotomous one, coded as 1 (event occurring) and 0 (event does not occurring). The independent variables can be interval level or categorical; if categorical, they should be dummy or indicator coded.

The logistic regression model is a multivariate technique for estimating the probability that an event occurs. Let Y be a dichotomous dependent variable:

$Y_i=1$, if the event occurs

$Y_i=0$, if the event does not occur.

Now we can define the dependence of probability of success on the independent variable for a single independent variable (X), the logistic regression is of the form:

$$\text{Prob(event)}=\text{prob}(y_i=1) = \frac{e^{\beta_0 + \beta_1 x}}{1 + e^{\beta_0 + \beta_1 x}}$$

Or equivalently,

$$\text{Prob}(\text{event}) = \text{prob}(y_i=1) = \frac{1}{1 + e^{\beta_0 + \beta_1 x}}$$

When β_0 and β_1 are the regression coefficients estimated from the data. For more than one independent variable, say x_1, x_2, \dots, x_k , which can either be qualitative or quantitative. The model assumes the form:

$$\text{Prob}(\text{event}) = \frac{e^z}{1 + e^z} \text{-----} (2.4.1)$$

Or equivalently,

$$\text{Prob}(\text{event}) = \frac{1}{1 + e^{-z}} \text{-----} (2.4.2)$$

Where, $z = \beta_0 + \beta_1 x_1 + \beta_2 x_2 + \dots + \beta_k x_k$

Equation (2.4.1) and (2.4.2) look complicated; however, the logarithm of the ratio of p_i and $1 - p_i$ which we called logit of p_i , turns out to be a simple linear function of x_{ij} .

We define,

$$\begin{aligned} \text{Logit}(p_i) &= \log_e \frac{p_i}{1 - p_i} \\ &= \sum_{j=0}^k \beta_j x_{ij} \\ &= \beta_0 + \sum_{j=1}^k \beta_j x_{ij} \text{-----} (2.4.3) \end{aligned}$$

The logit is the logarithm of the odds of success, that is, the logarithm of the probability of success to the probability of failure. It is also called the logistic transform of p_i and equation (2.4.3) is a linear logistic model.

In a logistic regression, the parameters of the model are estimated using the maximum likelihood. That is the coefficients that make our observed results most 'likely' are selected. To understand the interpretation of the logistic coefficients consider a rearrangement of the equation for the model. The logistic model can be re-written in terms of odds of an event occurring. It has several nice properties. First, as p_i increases, so odds logit (p_i). Second, logit(p_i) varies over the whole real line, whereas p_i is bounded only between 0 and 1. If p_i is less than 0.5, logit(p_i) is negative; while if p_i is greater than 0.5, logit (p_i) is positive.

From the equation (2.4.3), we see that the logistic coefficient can be interpreted as the change in the log odds associated with a one-unit change in the explanatory variable. Since it is easier to think of odds, rather than log odds, the logistic equation can be written in terms of odds as:

The exponential raise to the power β_j is the factor by which the odds change when j th independent variables increase by one unit. If β_j is positive the factor will be greater than 1, which means the odds are increased; if β_j is negative the factor will be less than 1, which means that the odds are decreases. When β_j is 0, the factors equal 1, which leaves the odds unchanged.

A statistic that is used to look at the partial correlation between the dependent variables and of the independent variables are R statistic. To fit a best model we have considered a full model with all the independent variables at a time. Then on the basis of odds ratio and it will be decided which variables are significant or not.

2.5 Software Used

Different software has been used to complete this study. The inter analysis of this study is done by most extensively used software that is SPSS (Statistical Package for Social Science) for windows (version 10.0). Excel 2000 and Ms Word 2000 are used simultaneously as they are also found to be necessary in different aspects.

BDHS 1999-2000 is installed in the SPSS for windows format. Hence, it is found to be much easier to read the data through this software. Different variables are computed as well as re-coded with it. Some first hand analysis such as frequencies, cross tabulations, construction of different tables, descriptive analysis, chi-square tests are performed through this software.

The logistic regression procedure builds logistic regression models, which is used to analyze the complex relationships of the study. Besides, SPSS, Excel 2000 is used to construct some of graphical outputs. The word procession software is used to prepare as well as presents all the outputs that are visible from this report.

Chapter Three

Background Characteristics

3.1 Introduction

In any survey it is essential to know the background characteristics of the target population. Information on the background characteristics is essential for interpretation of the survey results and examination of any cause-effect relationship among the study variables. In order to study these characteristics, it is required to have a glance on the percentage distribution of the selected variables because this shows the pattern of distribution and observations in different groups and would help to decide whether an individual variable is concentrated in a particular group or having considerably missing observations.

In this section an attempt has been made to discuss the background characteristics of husband and wife. In case of selecting background characteristics our interest lies on those variables which may have direct impact on the dependent variables. Some of the variables are found to be important from demographic point of view, while some others are from socio-economic point of view.

3.2 Background Characteristics

Table 3.1 shows that husbands are generally elder than their wives by about 9 years. Most of the husbands were of age 30 and above, while most of the wives were of age less than 30 years.

Age at first marriage is one of the most important factors in demography as it is directly related to fertility in many societies. Table 3.1 shows that about 79 percent of husbands were married at ages 20 or more while about 7 percent of wives were married at ages 20 or more, 19 percent of husbands and 27 percent of wives were married between ages 15 to 19 years. On the other hand about 3 percent of husbands and 66 percent of wives were married at ages below 15 years.

About 33 percent of husbands reported to have no formal education, the corresponding proportion of their wives is about 42 percent. As striking difference observe between husbands and wives in terms of higher education, 38 percent of husbands reported of having received secondary education and above whereas, 29 percent of wives had attained this level of education. From these figures, it is immediately apparent that Bangladeshi men are better educated than their wives.

The percentage distribution of husbands by their occupation is presented in table 3.1. As expected, a larger proportion of husbands (about 31 percent) are engaged in 'prof-tech-manag' profession and about 33 percent are found to be engaged in agriculture profession.

It is generally believed that employment status of women and men has some influence on the fertility desire and for this reason an attempt has been made to investigate whether the couples are involving any activities for earning cash income. In this study, very few wives are engaged in income generating activities. Only 19 percent wives are reported to be working for cash earning and the largest proportion of husbands (98 percent) are reported to be working for cash. 81 percent of wives and only 2.0 percent of husbands are not employed.

Table 3.1: Percentage distribution of couples by selected background characteristics; BDHS, 1999-2000

Background characteristics	Husband	Total cases	Wife	Total cases
Age				
Less than 30	18.7	421	53.5	1204
30-40	41.8	939	32.0	720
40 +	39.5	889	14.5	325
Mean age	38.59	2249	29.40	2249
Age at first marriage				
Less than 15	2.5	56	66.3	1492
15-19	19.0	427	26.5	596
20 or more	78.5	1766	7.2	161
Mean age	23.16	2249	14.93	2249

Background characteristics	Husband	Total cases	Wife	Total cases
Education				
No education	32.9	740	42.3	951
Primary	29.6	666	28.5	641
Secondary or higher	37.5	843	29.2	657
Work status				
Working	98.0	2201	18.8	423
Not working	2.0	48	81.2	1826
Mass media exposure to FP				
Have	74.7	1680	52.1	1171
No have	25.3	569	47.9	1077
Occupation				
Prof-tech-manag	31.0	697	1.2	27
Agri-self employed	26.0	584	-	-
Agri-employee	7.1	157	6.9	155
Skilled manual	12.7	287	7.3	164
Unskilled manual	20.5	462	3.0	68
Others	0.6	14	0.4	9
Not working	2.1	48	81.2	1826

Note: FP= Family Planning

In order to gauge the extent of family planning information and education activities, respondents in the 1999-2000 BDHS were asked if they had heard or seen a message about family planning on the radio, television, newspaper, magazine, or on a billboard or poster in the month before the survey. The results indicate that husbands are more likely to have mass media exposure to family planning compared to wife. For example, about 75 percent of husbands and about 52 percent of wives have reported that they had heard or seen a message about family planning.

Figure 3.1: Education level of the husband and wife

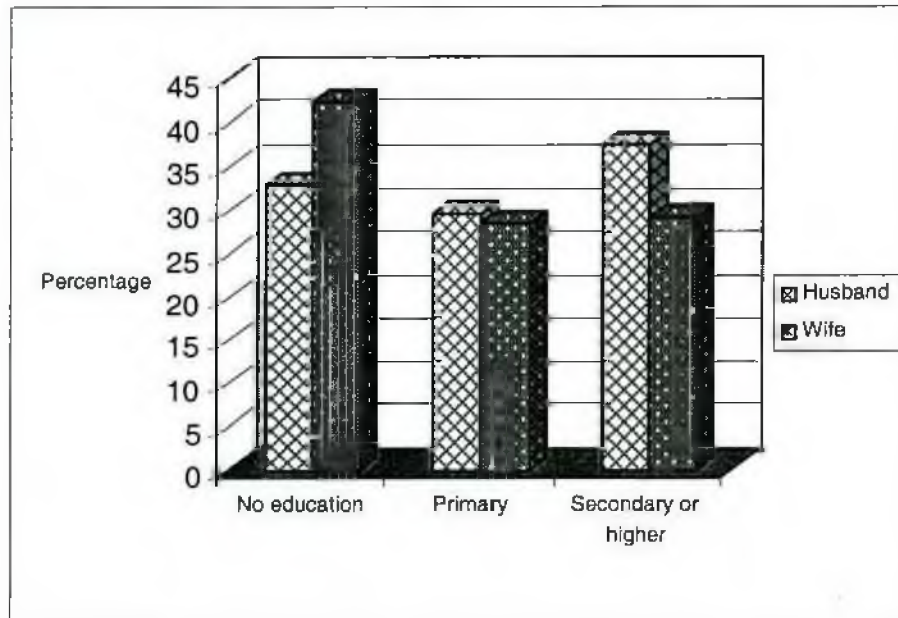


Table 3.2: Percent distribution of couples by the level of education

Education	Percent
Both husband and wife not educated	24.7
Wife educated, husband not	10.3
Husband educated, wife not	20.8
Both husband and wife educated	44.2
Total	2249

Knowledge, attitude and practices of contraceptive methods varies among the couples due to education. We can classify couples in a different way by education. The table 3.2 presents this form of classification. Here we observe that both husband and wife are educated by 44.2 percent. Along with this figure we see that both husband and wife have no education by 24.2 percent.

Table 3.3: Percentage of men and women by the status of mass media exposure

Mass media	Men	Women
No mass media	20.9	43.6
Read newspaper once a week	25.8	8.8
Watch television once a week	53.3	35.2
Listen to radio every week	52.5	28.8
All three media	13.4	4.3
Total	2556	10544

Mass media can expose male audiences to messages that can influence their reproductive health knowledge, attitudes and behavior. Strong media is needed to attain the goals of family planning programs. Radio is a powerful and common instrument to provide information easily regarding reproductive health matters. The table given above shows that radio is the common media the respondents has access. 52.5 percent men have listen to radio every week which is near about similar in case of television, 53.3 percent. On the other hand, women have less access to the mass media like radio and television. Only 28.8 percent women listen to radio every week.

3.3 Men's Opinion about Women's Greater Economic Participation

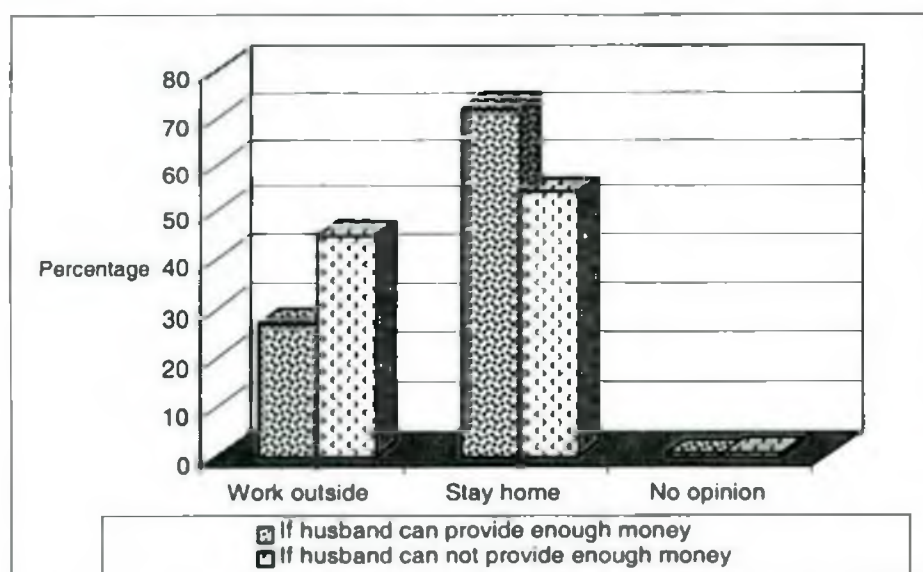
Gender disparity through and the dominance of men on women in many areas of life are the prime considerations for the development of any programme in sexual and reproductive health. This disparity mainly comes through wealth and assets. In our society women are not allowed to play greater economic role. Consequently the dependency on men makes women vulnerable. Men's reproductive behaviors are influenced by economic inequality.

The DHS data help us to understand the nature of men's attitude towards women's greater economic participation as it has important implication on reproductive health matters. In this context of gender dynamics equal share of income is expected in a family if both men and women are capable of doing jobs. As ours is a male dominating society, men make the decision whether women should go outside the house. From the table 3.4 it is clear that if men can bear well the family expenditures they don't prefer to allow women to go outside the house for any purpose even if it is income oriented. 72.2 percent men favor women to stay at home if men can provide sufficient income to the family.

Table 3.4: Percent distribution of Husband's opinion for married women to work outside the home

Respondents opinion	If respondents can provide enough money to take care of the household	If respondents can not provide enough money to take care of the household
Work outside the home	27.1	45.0
Stay home	72.2	54.2
No opinion	0.7	0.8
Total	2249	2249

Based on couple data

Figure 3.2: Husbands opinion for married women working outside the home**Table 3.5: Percent distribution of husband's attitude towards a wife role in household decision making**

Women should say about	Respondents opinion			Total
	Yes	No	No opinion	
Large household expenses	89.1	10.5	0.4	100.0
Minor daily household expenses	88.5	11.1	0.4	100.0
When to visit family, relatives or friends	83.4	15.4	1.2	100.0
What to do with money she earn	74.4	19.7	5.9	100.0

Table 3.5 presents husbands opinion about women's right to take decisions about household matters. 89 percent men have opined that women should have say about large family expenses. Similar things are observed in case of minor expenses. Men in this case have also given positive opinion. 74.4 percent respondents are in favor of

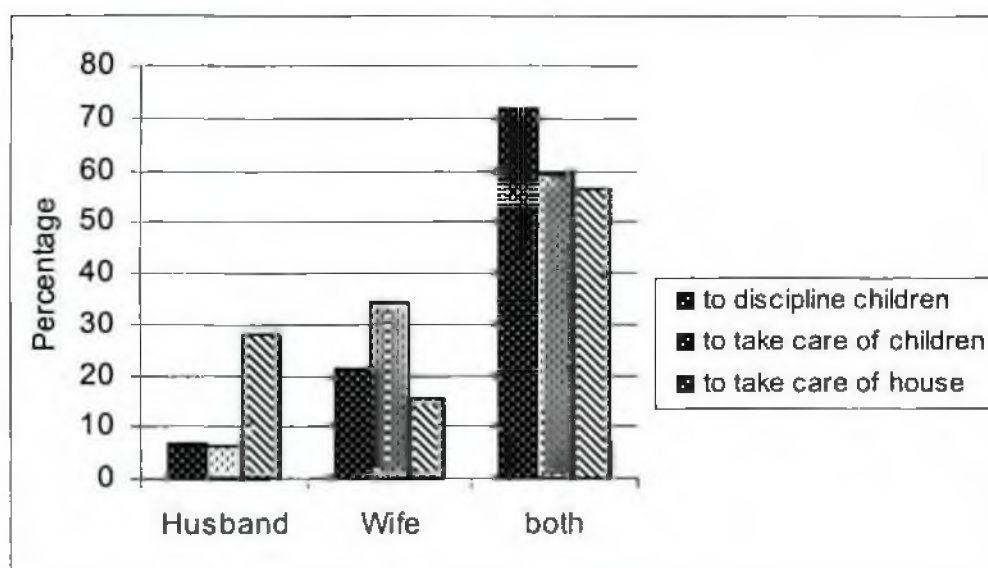
women's access to their own earnings. Men's obligation to permit women to visit friends and relatives women should stay at home. That is, their mobility is restricted. But interestingly, in the BDHS data we find that 83 percent men are in favor of women's choices to visit friends and relatives. These observations are contradictory to the earlier results found in case of women's access to work outside the home.

Table 3.6: Percent distribution of husbands about who should have the main responsibility to take care of family and family members

Who should have the main responsibility	Husband	Wife	Both	Total
To discipline children	6.8	21.2	72.0	100.0
To take care of children	6.3	34.3	59.4	100.0
To take care of house	28.0	15.6	56.4	100.0

Respondents views regarding children's care obtained from the study also tell in favor of equal responsibility. 72 percent men said that both men and women should take the responsibility to discipline children and 59 percent for taking care of children.

Figure 3.3: Who should have the main responsibility to take care of family and family member



3.4 Men's Opinion about Abusing Women

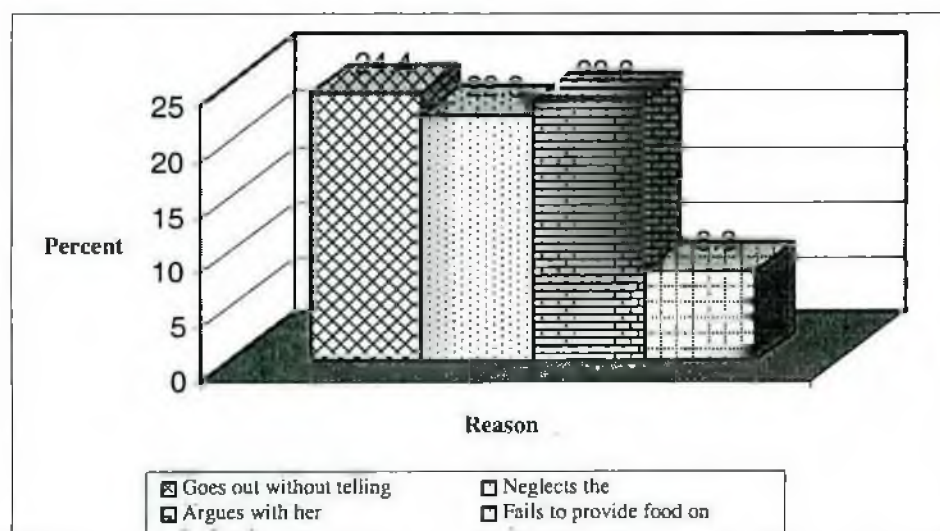
Seriously physical abuse and harassment are the common phenomena in Bangladesh, particularly in rural areas. To get rid of this situation, women's more empowerment and economic participation is needed.

Table 3.7: Respondents (husbands) justification about beating wife

Reasons	Percent
Goes out without telling him	24.4
Neglects the children	22.3
Argues with her husband	23.6
Fails to provide food on time	8.3
Agrees with at least one specific reason	36.1
Agrees with no reason	63.9
Total number of men	2556

Majority of the respondents agrees with no specific reasons to beat their wives when they were asked to give their justification for beating wife. Most devastating result is observed from the table- when we see that some of the respondents are justifying the reason to beat their wives. 24.4 percent respondents said that women should be beaten up for going out without telling them. 22.3 percent of respondents are found in case of the reasons like neglecting children and 23.6 percent for arguing with their husband. At the end we see that 36 percent respondent agrees with at least one specific reason for beating wife. These figures express the rude nature of some men towards women.

Figure 3.4: Men's justification to beat wives



Chapter Four

Men's Knowledge, Attitude and Practice of Family Planning

4.1 Introduction

Recent research has provided evidence from varied settings that spousal involvement increases the likelihood of using contraception and its continuation. Men's knowledge and attitude towards family planning play important role in promoting and practicing family planning among the couples.

Studies have demonstrated that inter spousal communication between husband and wife played a key role in regard to initiation of family planning technique (Farooqui, 1994).

Numerous studies have also shown that reproductive health interventions that target both members of couples are more effective than those same interventions aimed at one sex only. Studies conducted in Sri Lanka and Nepal has found inter-spousal communication to be highly predictive of the use of modern family planning methods (Silva, 1994; Kane and Sivasubramanium, 1989).

This chapter provides a brief review of the Bangladesh family planning programme from gender perspectives and examines men's knowledge, attitude and practice of family planning in Bangladesh. It also analyzes men's role and influences in reproductive decision making in Bangladesh and determinants of men's contraceptive use.

4.2 Family Planning Programme in Bangladesh: A Gender Biased Programme

The family planning programme in Bangladesh has been considered as one of the success story in a setting without much improvement in socio-economic and health indicators that are thought to be needed for the success of the programme. The dramatic increase in the use of family planning methods from a low level of 8 percent in 1975 to 54 percent in 1999-2000 and the corresponding decline in the fertility level from 6.3 births per women in 1975 to 3.3 births per women in 1999-2000 (Mitra et al., 2001) have been attributed in large part to massive efforts made to expand access to family planning methods and services and to motivate people to use them (Philips et al., 1988; Mauldin and Ross, 1991; Larson and Mitra, 1992; Cleland et al., 1994; Islam et al., 1998). In the backdrop of persistent poverty, high mortality, low literacy, and the patriarchal social norm of early marriage of girls, seclusion of women and adolescent girls and preference for sons, the population transition that has begun in Bangladesh is particularly remarkable.

The national family planning programme in Bangladesh could be described as “culturally sensitive” and “gender bias”. It uses strategies that acknowledge and accommodate gender inequalities in providing services to women in their home through female workers keeping men out of information and services (Larson and Mitra, 1992; Schuler et. al., 1995). Currently about 30,000 female workers working in their own villages or nearby villages throughout the country. Their primary functions are to inform women about various methods of contraception and motivate them to use contraceptives; to supply them contraceptive methods; and to refer women who want clinical methods to appropriate sources. Such women centered, door to door service delivery approach, however, has been very effective in transforming reproductive norms in rural Bangladesh, but leads to many problems such as over reliance on the village-based female workers, unbalanced method mix, misinformation about methods and availability of safe abortion or menstrual regulation services, fear of side effects, and inadequate assistance with side effects. Instead of attempting to engage men, the programme places the responsibility for family planning disproportionately on women, who lack the resources to deal with its costs and risks.

Men in Bangladesh often give permission to their wives to practice contraception in a noncommittal way, without actually making a decision themselves; if anything goes wrong, they can blame their wives (Schuler et. al., 1995). Men have authority, but often they are reluctant to take responsibility. Schuler and others also has observed that the family planning programme in its current form does little to promote men's involvement in family planning which is a problem for women.

4.3 Knowledge of Contraception

Usually knowledge of contraceptive methods refers to whether a respondent heard of or known of a family planning method or methods. Contraceptive knowledge or awareness logically proceeds contraceptive use, and it is therefore important to know that if men have proper knowledge of contraception or of specific contraceptive methods. But the Demographic and Health Surveys data on knowledge do not necessarily mean that the respondent knows how to use the method, understands its effectiveness or side effects, or approves of it.

In the BDHS data, contraceptive methods are grouped into two categories. One is modern method and the other is traditional method. Modern methods include Pill, IUD, Injectable, Condom, Female and Male sterilization, Norplant. Traditional methods include Withdrawal, Periodic abstinence (safe period or rhythm method) and other methods such as herbal remedies.

The results indicate that knowledge of at least one method is universal among Bangladeshi men. Table 4.1 shows that pill and condom are the widely known methods in case of both men and women. Nearly all women and men are aware of pill. But men's knowledge in case of condom is higher than that of women.

Table 4.1: Percentage of currently married men and women by the knowledge of specific contraceptive method, Bangladesh 1999-2000

Contraceptive method	Currently married men	Currently married women
Any modern method	100.0	99.9
Pill	99.9	99.8
IUD	69.5	89.6
Injectable	92.6	98.1
Condom	97.2	89.8
Female sterilization	94.8	97.5
Male sterilization	87.4	77.0
Norplant	24.6	56.3
Any traditional method	82.4	79.9
Periodic abstinence	73.8	66.9
Withdrawal	47.2	56.8
Other	8.0	7.8
Total	2556	9720

Men are less likely to know about IUD, Norplant and withdrawal. Knowledge on female and male sterilization is respectively 94.8 and 87.4 percent in case of men. Among all modern methods, Norplant is the method which is least known by men (only 24.6 percent). Interestingly, women's knowledge (56.3) about Norplant is much higher than that of men.

Men's knowledge regarding traditional methods is much lower than that of modern methods. Only 82.4 percent men have heard of traditional methods while it is 100 percent in case of modern methods.

Table 4.2: Percentage of men's knowledge about contraceptive methods by level of education, Bangladesh 1999-2000

Contraceptive method	Education			
	No education	Primary	Secondary	Higher
Modern method				
Pill	99.9	99.9	99.9	100.0
IUD	59.8	66.0	79.7	88.0
Injectable	91.0	91.8	94.6	95.6
Condom	94.8	97.3	99.3	100.0
Female sterilization	92.7	94.1	96.6	99.7
Male sterilization	83.7	85.2	90.8	97.3
Norplant	20.1	22.1	28.0	38.4

Contraceptive method	Education			
	No education	Primary	Secondary	Higher
Any traditional method				
Periodic abstinence	65.8	72.5	79.8	89.4
Withdrawal	34.9	42.3	57.1	78.2
Other	6.2	8.6	9.2	9.9

Table 4.2 presents men’s knowledge about family planning methods by level of education. The results indicate that the level of education of the men did not play any distinct effect in knowing some methods like pill, condom and injectables, but for other methods it has significant positive relationship with the knowledge. Nearly equal percentages of respondents for different levels of education show that they are aware of pill, condom, injectables and female sterilization. On the other hand, in case of IUD, periodic abstinence and withdrawal there is some significant variation among the respondents having different levels of education.

4.4 Attitude towards Family Planning

In this section we analyze couples attitude towards family planning, and spousal communication about contraceptive use in Bangladesh.

Table 4.3: Percentage of couples by attitude toward family planning, Bangladesh 1999-2000

Attitude	Percent	Total number of cases
Wife’s perception of husband’s attitude		
Approve family planning	84.9	1909
Disapprove family planning	15.1	340
Wife’s attitude towards family planning		
Approve family planning	94.7	2129
Disapprove family planning	5.3	120
Joint attitude toward family planning		
Both approve	84.2	1894
Only husband approves	0.7	15
Only wife approves	10.5	236
Neither approves	4.6	104

Attitude	Percent	Total number of cases
Spousal discussion of family planning		
Discussed about family planning	49.6	1116
Never discussed about family planning	50.4	1133
Total	-	2249

Based on couple data

Attitude toward family planning refers to whether a respondent approves of family planning to prevent pregnancy. Table 4.3 shows the percentage of couples who approve family planning. The results indicate that 95 percent of wives approve family planning. Table 4.3 also shows that about 85 percent of wives believed that their husbands approve family planning. About 4.6 percent cases both husband and wife disapprove family planning, while in about 84 percent cases both approve family planning. About 50 percent spouse discuss about family planning among themselves.

4.5 Men's Contraceptive Use

Men have very limited choice of family planning methods to use. Prior to the development of modern methods of birth control, men used to limit fertility through use of some traditional methods. Among them withdrawal is most important. Condom and vasectomy (male sterilization) are only two modern male methods.

In the BDHS survey current use of contraception is defined as the proportion of women and men who report that they are using a family planning method at the time of interview.

In BDHS, a current use rate of family planning methods are evaluated by asking husbands or wives these two questions:

"Are you currently doing something or using any method to delay or avoid getting pregnant?"

And if the respondent answers in the affirmative,

"Which method are you using?"

Thus rates of current use reported here refer to the numbers who were using family planning methods at the time when the survey was undertaken. Table 4.4 shows the percent distribution of currently married women and men by method specific current contraceptive use.

Table 4.4: Percentage of male methods and their contribution to contraceptive prevalence rate, Bangladesh 1999-2000

Use of contraceptive methods	Percent (n=9,720)
Any method (CPR)	53.8
Any male method	14.2
Any female method	39.6
Modern male method	4.8
Condom	4.3
Vasectomy (male sterilization)	0.5
Traditional male method	9.4
Periodic abstinence	5.4
Withdrawal	4.0
Contribution of all male method to CPR	26.4
Contribution of male modern method to CPR	8.9
Contribution of male traditional method to CPR	17.5

More than half (54 percent) of the currently married women and their husbands are practicing any family planning method. However, the prevalence of male method use is very low. Of the total contraceptive prevalence rate (CPR), only 14 percent are due to male methods, accounting 26 percent of the total use (table 4.4). If only modern methods (condom and vasectomy) are considered, the corresponding figures becomes even less (4.8 and 8.9 percent respectively). Thus, the major part of the male methods are due use of traditional methods (periodic abstinence and withdrawal).

4.6 Trends in Current Use of Contraceptive Methods

Contraceptive prevalence has steadily grown in Bangladesh since 1975. In 1975, only 8 percent of currently married women reported using a family planning method, compared with 54 percent in the 1999-2000 BDHS survey- a sevenfold increase in the contraceptive prevalence rate for any method over the last 25 years. The prevalence of

modern methods has increased even faster, more than eightfold, from 5 percent in 1975 to 43 percent in 1999-2000.

Between the 1996-1997 and 1999-2000 BDHS survey, overall contraceptive use increased by 9 percent, from 49 to 54 percent of currently married women, almost as much as it had increased between the 1993-1994 and 1996-1997 BDHS survey.

Table 4.5: Trends in current use of contraceptive methods

Methods	1975 BFS	1983 CPS	1985 CPS	1989 BFS	1991 CPS	1993- 94 BDHS	1996- 97 BDHS	1999- 2000 BDHS
Vasectomy	0.5	1.2	1.5	1.2	1.2	1.1	1.1	0.5
Condom	0.7	1.5	1.8	1.8	2.5	3.0	3.9	4.3
Withdrawal	0.5	1.3	0.9	1.8	2.0	2.5	1.9	4.0
Total male methods	1.7	4.0	4.2	4.8	5.7	7.6	6.9	8.8
Periodic abstinence	0.9	2.4	3.8	4.0	4.7	4.8	5.0	5.4
Total female methods	5.1	12.7	17.3	22.0	29.5	33.2	37.3	39.0
Any method	7.7	19.1	25.3	30.8	39.9	44.4	49.2	53.8

BFS= Bangladesh Fertility Survey

CPS=Contraceptive Prevalence Survey

BDHS=Bangladesh Demographic and Health Survey

Although the noticeable success has been achieved in raising the overall prevalence of contraceptive use in recent times, the fact is that the rate of contraceptive use performed by male is frustrating. According to different demographic and health surveys organized in different times, the percentage use of female methods is highly satisfactory. According to these reports, we see that, the prevalence of strictly male method use in 1999/00 was 8.9 percent. This share out of the uses of all methods was only 14 percent. In the previous study, that is, in 1996/97 the same figure observed regarding male percentage use. At the same time, the percentage use of female methods has increased remarkably, from 5.1 percent in 1975 to 39.0 percent in 1999/00. This is achieved due to the target oriented policy focusing on women. So it is clear that men's role on contraceptive use was ignored in this period. Therefore the need to formulate more dynamic and suitable programs to increase men's percentage share in contraceptive using is assessed.

Figure 4.1: Trends in male method use, female method use and CPR 1975-2000

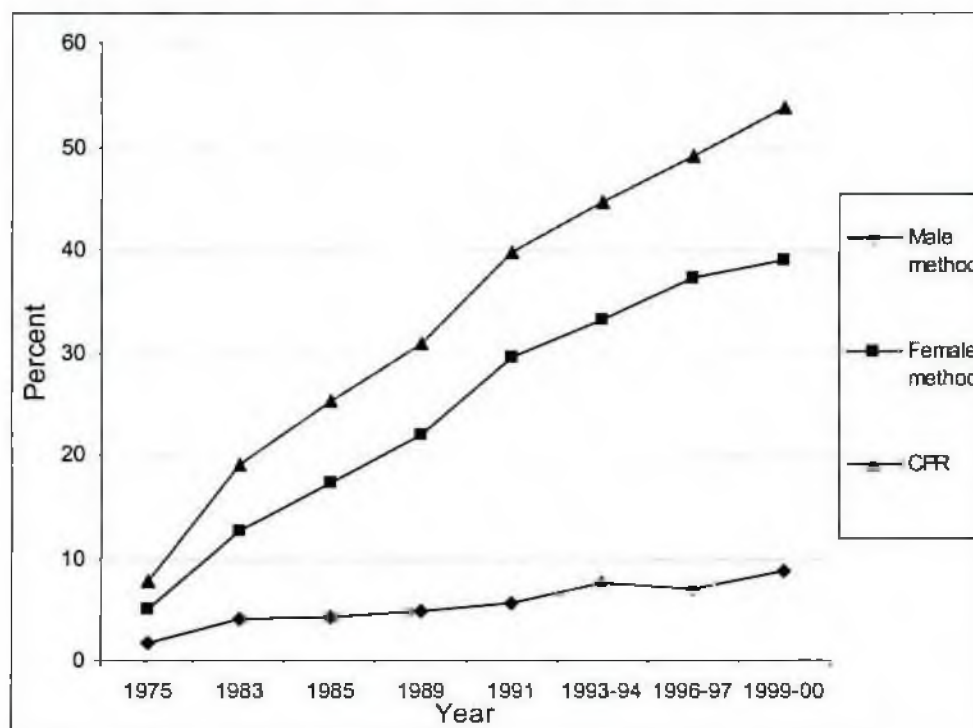


Figure 4.1 presents that all other male methods show increasing trends like the CPR and female methods. The increases in female methods use is more pronounced than male methods. The figure also demonstrates that the proportional use of male methods has decreased while the CPR has steadily risen.

Table 4.6: Percentage distribution of husbands who have currently used any method according to CPS 1989, BDHS 1996-97 and BDHS 1999-2000

Contraceptive method	1989 CPS	BDHS 1996-67	BDHS 1999-2000
Any method	35.8	58.9	65.1
Condom	3.1	6.0	6.5
Male sterilization	1.5	1.6	0.6
Safe period	5.6	8.2	9.6
Withdrawal	0.9	1.6	2.4
Total	1789	3312	2249

Rates of current use as reported in the CPS 1989, BDHS 1996-97 and BDHS 1999-2000 presented in the table 4.6. In the CPS 1989, 36 percent of husbands reported that they were currently using any family planning method. In the BDHS 1996-97, this currently using any method rose to 59 percent and in BDHS 1999-2000 this rate of

practicing rose to 65 percent. From this comparison we have seen that the practice of family planning methods is increasing day by day but the use of permanent methods are decreasing.

4.7 Differentials of Men's Contraceptive Use

In this section we have examined the levels and differentials in current use of contraception (modern and traditional) of currently married men. Different selected demographic and husband-wife communication characteristics are included in this analysis.

Differentials of men's contraceptive use are examined here in order to identify those subgroups that may be particularly successful in using male contraceptive methods and second, the broader set of programmatic and non-programmatic factors, which influence contraceptive behavior. The following variables are included in the differential analysis, undertaken in this section: age, place of residence, division, education of the respondents, occupation of the respondents, religion, current use of contraception, ideal number of children, ideal number of son, exposure to mass-media, desire for more children, number of living children.

Table 4.7: Percentage of husbands according to use of any male methods by background characteristics: BDHS 1999-2000

Background characteristics	Men's contraceptive use	No. of respondents
Age of husbands		
<30	9.5	421
30-40	8.2	939
40+	10.8	889
Place of residence		
Urban	13.9	690
Rural	7.5	1559
Division		
Barisal	8.5	199
Chittagong	8.2	389
Dhaka	9.8	582
Khulna	12.6	404
Rajshahi	8.7	460
Sylhet	7.4	215

Background characteristics	Men's contraceptive use	No. of respondents
Husbands education		
No education	4.6	740
Primary	5.4	666
Secondary or higher	17.0	843
Education of wife		
No education	5.9	951
Primary	6.4	641
Secondary or higher	17.7	657
Husbands occupation		
Prof-tech-manag	14.2	692
Agri-self employed	6.7	581
Agri-employed	7.5	159
Skilled manual	9.5	283
Unskilled manual	5.7	457
Others	14.3	77
Husbands approve FP		
No	2.6	340
Yes	10.7	1907
Discuss FP with wives		
No	8.1	1314
Yes	11.3	934
No. of living children		
0	10.0	201
1-2	10.6	939
3-4	8.4	700
5+	8.3	409
Religion		
Muslims	9.5	1925
Non-Muslims	9.3	321
Ideal no. of children		
0-2	21.8	1429
3-4	16.2	624
5+	8.2	196
Exposure to mass-media		
No	4.1	434
Yes	10.7	1815
Summery of the table		
Using any male contraceptive method	9.5	213
Not using	90.5	2036

Based on couple data

Active participation of male varies according to the age of them. From table 4.7 we found that use of family planning among husbands of age 40 and above compared to their younger counterparts. The level of active participation is higher in urban areas than in rural areas (13.9 percent vs. 7.5 percent).

Divisional variation is seen in the rate of men's contraceptive use. Active participation of male is much lower in Sylhet division while in Khulna division it is the highest according to husband's report. Only 7.4 percent of husbands in Sylhet division and 12.6 percent of husbands in Khulna division reported themselves as users of male methods (table 4.7).

Men's contraceptive use differs by educational level. While 4.6 percent of husbands with no education are participating family planning methods the proportion rises to over 5.4 percent among husbands with some primary education. The rate rises further, reaching to a high of around 17.0 percent who have secondary or above level of education. Like husbands' education wives' education also related with men's contraceptive use. Husbands' whose wives' have secondary or above level of education are more likely to use family planning methods compared to those whose wives have no education. For example, about 18 percent of the husbands with wives having secondary or above level of education are practicing family planning methods; the corresponding figure for those with wives having no education is only 6 percent.

Male contraception varies according to husband's profession. Husbands involved with white collar job have higher prevalence of contraceptive use than the husbands involved with other occupation.

Husbands attitude towards family planning have shown some differential effect on their current use of contraception. Among the husbands who approve FP the active participation rate is about 10.7 percent while it is only 2.6 percent among the husbands who do not approve FP. Family planning discussion with partner is the most important differential effect on contraceptive use. Husbands who talk to their wife about family planning are more positive to use male contraceptive methods.

Number of living children shows negative association with the current contraceptive use of husbands. From the data we have seen that at first when the number of living children is 0 the active participation rate is 10.0 percent, as the number of living children increases to 3-4 the rate of contraceptive use decreases to 8.4 percent. Among the husbands with number of living children 5 or above the active participation rate is 8.3 percent. Ideal number of children has shown some differentials effect on current use of contraception. Among the husbands who expect one or two children as ideal family size are higher user of male methods (11.8 percent) compared to those who expect 3 or 4 children (6.6 percent). Among the husbands who expect 5 or above number of children the active participation rate is 1.5 percent.

Religion of husband does not show any differential effect on contraceptive use.

Mass media exposure has great effect on use of male contraceptive method. The respondents, who have exposure to radio, television or newspaper, 10.7 percent are currently using contraceptive methods compared to 4.1 percent of those who have no mass media exposure.

4.8 Men's Influence on Contraceptive Use

In this section we analyze the role of husbands in reproductive decision-making by focusing on their preferences concerning family size and having additional children, their attitude towards family planning, and how spousal communication effects on couples contraceptive use and childbearing.

Table 4.8 shows that when both the partner approve of family planning, the reported contraceptive use rate is higher than the couples in which either the wife or the husband alone reported approval. Contraceptive use rate is substantially higher among the couples when husband alone approve the family planning than when wife alone approve family planning (53 percent Vs 32 percent) indicating that husbands attitude have more influence than wife's attitude. The table shows a similar relationship for spousal desire for no more children and contraceptive use.

Table 4.8: Percentage of wives reporting current use of contraceptive method and by various attitudes of the couple toward family planning and fertility issues, Bangladesh 1999-2000

Attitude	Percentage of current users (n=1338 couples)
Couples approval of family planning	
Both approve	63.3
Only husband approves	53.3
Only wife approves	32.1
Neither approves	20.5
Wife's perception of husband's attitude	
Approve family planning	65.9
Disapprove family planning	27.1
Wife's attitude towards family planning	
Approve family planning	61.5
Disapprove family planning	24.2
Spousal discussion of family planning	
Discussed about family planning	71.6
Never discussed about family planning	47.7
Spousal desire for no more children	
Both want no more	71.1
Husband want no more	67.0
Wife want no more	62.9
Both want more	46.7
Spousal preference for ideal family size	
Both preferred same	62.5
Husband's preference > wife's preference	51.3
wife's preference > Husband's preference	63.2
Total	59.5

Based on couple data

The hypothesis that both partners play a role in the adoption of contraception is reinforced by the association between wives' reported contraceptive use and their perceptions of their husband's attitude toward use of family planning. In couples in which the husband approved of family planning, the proportion of women currently using a method was 66 percent among those who believed their husband approved, compared with 27 percent among those who believed their husband disapproved.

Interspousal communication is also an important factor determining the contraceptive use. Contraceptive use rate is substantially higher among the couples who ever discussed about family planning than who never discussed about it (72 percent vs 48 percent).

We used logistic regression to further explore the role of husbands and wives in the adoption of contraception. Table 4.9 shows two sets of models that examine the effect of each of the attitudinal and fertility related variables. The models in the first column include only the variable of interest; those in the second column include other background variables that we identified as confounding factors such as wife's age, education, work status, place of residence, region of residence and husband's education.

When no controls for confounding variables were included, both of the spouses and the wife's approval of family planning were significantly associated with current contraceptive use; the husband's approval was only marginally significant ($p < .10$). However after we introduced controls for confounding factors, the husband's approval appears to have no significant effect but both of the spouses and the husband's approval remained as significant predictor of contraceptive use ($p < .05$).

Couple's desire for no more children has significant effects on contraceptive use. However, the effect of husband's desire is more pronounced than the effect of wife's desire on contraceptive use. Couples in which the husband wanted no more children were more likely to be practicing contraception than were those in which the wife wanted no more children. This association remained significant even after the effects of confounding variables were controlled.

Table 4.9: Logistic regression of current use of contraception on some selected demographic and socio-economic factors among the couples; BDHS, 1999-2000

Attitude	Uncontrolled	Controlled
Couples attitude toward family planning		
Both approve	2.78**	2.17**
Only wife approves	1.85**	1.76**
Only husband approves	1.30	1.11*
(Both disapprove)	1.00	1.00
Wife's perception of husband's attitude towards family planning		
Wife says husband approves FP	5.55***	3.14***
(Wife says husband disapprove FP)	1.00	1.00
Spousal discussion of family planning		
Discussed about family planning	1.93***	2.11***
(Never discussed family planning)	1.00	1.00
Spousal desire for no more children		
Both want no more	3.33***	2.81***
Husband want no more	2.69***	1.94***
Wife want no more	1.57**	1.16**
(Both want more)	1.00	1.00

Note: * $p < .10$, ** $p < .05$, *** $p < .01$; reference category are in parenthesis;

FP= Family Planning

Couples who were reported to be discussed about family planning were more likely to use contraceptive methods than those who never discussed about family planning. The effects remain significant even when confounding variables were controlled.

Wives who believed that their husband approved of family planning were significantly more likely to be practicing contraception than were those who felt their husband disapproved or those who said they did not know their husband's attitude. As the results in the second column show, this relationship persisted even when confounding background factors were controlled.

Overall, the husband's attitudes and preferences appeared to be more strongly associated than her wife's with her report of current contraceptive use. The results nevertheless suggest that both partners play a role in the adoption of contraception.

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Attitude	Uncontrolled	Controlled
Couples attitude toward family planning		
Both approve	2.78**	2.17**
Only wife approves	1.85**	1.76**
Only husband approves (Both disapprove)	1.30 1.00	1.11* 1.00
Wife's perception of husband's attitude towards family planning		
Wife says husband approves FP (Wife says husband disapprove FP)	5.55*** 1.00	3.14*** 1.00
Spousal discussion of family planning		
Discussed about family planning (Never discussed family planning)	1.93*** 1.00	2.11*** 1.00
Spousal desire for no more children		
Both want no more	3.33***	2.81***
Husband want no more	2.69***	1.94***
Wife want no more (Both want more)	1.57** 1.00	1.16** 1.00

Note: * $p < .10$, ** $p < .05$, *** $p < .01$; reference category are in parenthesis;

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Overall, the husband's attitudes and preferences appeared to be more strongly associated than her wife's with her report of current contraceptive use. The results nevertheless suggest that both partners play a role in the adoption of contraception.

4.9 Intention to Use Contraceptives in Future

Intention to use contraception in the future provides an indicator of disposition toward contraception among nonusers. An important indicator of the changing demand for family planning is the extent to which nonusers of contraception plan to use in the future. All currently married respondents in the BDHS survey who are not using contraception at the time of the survey were asked about their intentions to use a use a family planning method at any time in the future. Table 4.10 shows the percent distribution of currently married men and women by their intention to use family planning in the future.

Table 4.10: Percent distribution of currently married men and women who are not currently using any contraceptive method by intention to use in the future, Bangladesh 1999-2000

Future intentions	Currently married men	Currently married women
Intends to use	62.0	71.3
Unsure about use	4.3	2.7
Does not intend to use	32.9	25.7
Missing	0.8	0.3
Number of men/women	934	4494

The male non users say that they intend to use family planning in the future, 62 percent compared with 33 percent not intending to use. Intention to use family planning is less common among men than that of women, 62 versus 71 percent.

4.10 Reason for Not Participating in the Contraceptive Practice

In the beginning of working for popularizing contraceptive practice in Bangladesh, people were not participating willingly in contraceptive use. Whenever family planning workers started to go door to door to convince men and women having reproductive capability, people began to accept different contraceptive methods. They began to realize the need of controlling population for the sake of betterment of their lives. But unfortunately the achievement is not so illuminative. Moreover men's participation is negligible. The reasons for not participating are manifold. The reasons as observed can be divided into four major groups. Fertility related reasons, opposition to use, lack of knowledge; method related reasons are found in this study.

Table 4.11: Percent Distribution of reasons for not using contraceptive methods reported by respondents

Reason for not intending to use contraception	Percent
Fertility related reason	60.7
Not having sex	3.4
Infrequent sex	5.0
Menopausal/hysterectomy	20.8
Subfecund/infecund	20.6
Postpartum amenorrheic	0.6
Breast feeding	0.2
Fatalistic	10.1
Opposition to use	15.4
Respondent opposed	10.7
Partner opposed	0.5
Religious prohibition	4.2
Lack of knowledge	1.5
Knows no method	0.2
Knows no source	1.3
Method related reasons	6.7
Health concerns	1.6
Fear of side effects	4.4
Cost too much	0.5
Other	15.6
Total	100.0
Number of men	307

Table 4.11 presents data on the main reasons for not using family planning. Fertility related reasons are mainly the results of biological causes. Fertility related reason include menopausal, hysterectomy, sub fecund, post-partum amenorrhea, breastfeeding etc. 60.7 percent respondents are explaining the reasons of unwillingness to use in this group. Among the various reasons of this group menopausal/hysterectomy and subfecund/infecund are the major reasons. As the couples having this type of problems are not capable of giving a live birth so the question of contraceptive practice didn't arise here. We found 41.4 percent respondent's not using contraceptive methods have such type of problem. Respondent not having sex or infrequent sex give 8.4 percent non user.

Respondent's attitudes towards contraceptive methods are expressed in the group like opposition to use. 15.4 percent respondents are showing their unwillingness to use contraceptive methods, of which 10.7 percent respondents under study directly oppose

to the idea of contraceptive practice. Respondents religious believe prohibited them from using contraceptive methods in 4.2 percent cases.

The available contraceptive methods sometime put a barrier to practice these. Usually the couples fear of getting side effect from practicing of contraceptive methods. Lack of knowledge and other accounts to figure 17.1 percent non user. Respondents lack of knowledge here show only 1.5 percent non users.

These are the actual picture of the respondent's views and behaviors regarding contraceptive practice. We think these findings will facilitate to get an idea about the performance of couples, particularly men, in the contraceptive practice in Bangladesh.

Chapter Five

Fertility Preference of Men

5.1 Introduction

In most of the developing world, fertility has declined so rapidly that the trend has been called “extraordinary”, reflecting “fundamental changes on reproductive attitudes and behavior” (Freedman and Blanc, 1991). An identifying mark of child bearing is the fertility preference of men and women. Fertility preferences are important because it indicates women’s and men’s attitude toward their future fertility. Changes in ideal family size over time may be attributed by the shift in attitude of both men and women. Although these attitudes may not perfectly presage actual future behavior, it can demonstrate prevailing social norms about family size.

The fertility level of a country is closely related to the percentage of couples of reproductive age that does not want to have more children. Using the DHS data from eighteen countries, John Bongaarts (Bongaarts, 1990) found that fertility of women who do not want to have more children is fifty eight percent below than that of women of comparable age who still want to have more children. In fact, the percentage of women who do not want more children has proved to be an accurate short-term prediction of fertility rates (Westoff, 1991).

The desire for more children tends some insight into the process of changing family size norms. The desire for more children may largely depend on the current age, and number of the living children. Adding the number of additional children desired to a women’s actual number of living children gives a surrogate measure of prevailing individual family norms. Family size norms may have programmatic value since the decision to adopt contraception is likely to be, in part, influenced by individual family norms (Kamuansipa and Chamrathirong, 1982).

The overall fertility norms supported by traditional culture in Bangladesh is still in favor of a large family size, coupled with a strong son preference. Ongoing changes

are already contributing to a reduction in the desired family size and a moderate decline in the son preference, which traditionally led to high fertility in the process of pursuit of a male child. Premonition of child survival; enhancement of quality of life; provision of minimal education across social classes; institutional arrangement to ensure alternatives to male children as a source of security for the old, the widows, and in the face of other uncertainties; enhancement of female status in the community; changing the inheritance system, which currently discriminates against women; offering tangible gains of lower fertility to the common men, especially those below poverty line-these are all preconditions for sustaining small family norms at the societal level.

In this chapter we investigate the patterns and differentials of men's desire for no more children and desired number of children in Bangladesh. We study the differential with respect to some selected demographic, socioeconomic and husband-wife communication characteristics. We examine the consistency between ideal and actual number of living children. In this chapter also examine the factors affecting reproductive desire of men by a logistic regression analysis.

5.2 Desire for More Children

The desire for children is the variable, which can provide the information regarding the fertility preference. In the BDHS, both husbands and wives were asked,

"would you like to have (a/another) child or would you prefer not to have any (more) children?"

Overall, more than sixty percent (62 percent) of men did not have desire for more children.

Table 5.1: Percentage distribution of currently married men age less than 40 years and age 40 or more years having desire for another child, BDHS, 1999-2000

Fertility preference of men	Current age of men		Total
	Age less than 40 years	Age 40 or more years	
	Percent	Percent	Percent
Desire for more children	50.9	9.6	34.1
No more children	44.9	87.2	62.0
Undecided	4.2	3.2	3.9
Total	100.0	100.0	100.0
Number	1215	833	2048

Desire to have more children is closely related to the age of respondent. A man is more likely to stop childbearing of his wife, if they tend in older age group. So, to have a clear idea about future fertility preference, we make analysis by controlling the current age of the respondent and the results are presented in table 5.1. It may be seen that, the proportion of desire for no more children was 44.9 percent among the younger men (age less than 40 years), while it is 87.2 percent among the older men (age 40 or more years). (Sterilized husband were excluded from the analysis)

5.3 Differentials of Men's Fertility Desire

Differential in the desire for no more children for currently married men aged 15-59 are presented in this analysis. The set of characteristics which are considered are living children, living son, ideal number of children, child loss experience, administrative division, place of residence, education of respondents, occupation of the respondents, religion and exposure to mass media.

Table 5.2: Percentage distribution of currently married men age 15-59 having desire for future child by selected background characteristics: BDHS 1999-2000

Background characteristics	Number of respondents	Want more	Want no more	Undecided
Age of the husbands				
<30	421	77.2	19.7	3.1
30-40	902	34.6	60.6	4.8
40+	725	8.4	88.4	3.2

Background characteristics	Number of respondents	Want more	Want no more	Undecided
Place of residence				
Urban	638	34.8	61.8	3.4
Rural	1410	33.8	62.2	4.0
Division				
Barisal	179	30.7	66.5	2.8
Chittagong	356	34.3	62.9	2.8
Dhaka	543	34.4	59.9	5.7
Khulna	372	32.8	64.8	2.4
Rajshahi	397	36.3	62.5	1.2
Sylhet	201	33.8	56.7	9.5
Husbands education				
No education	649	34.4	61.9	3.7
Primary	609	32.2	62.9	4.9
Secondary or higher	790	35.3	61.5	3.2
Husbands occupation				
Prof-tech-manag	635	31.5	63.6	4.9
Agri-self employed	525	32.4	64.4	3.2
Agri employed	145	37.9	58.6	3.5
Skilled manual	263	40.7	57.0	2.3
Unskilled manual	414	32.9	63.3	3.8
Others	66	45.5	48.5	6.0
Living children				
0	196	96.9	1.5	1.6
1-2	897	48.2	46.6	5.2
3-4	603	10.9	85.7	3.4
5 or more	352	2.8	94.6	2.6
Husband approve F.P				
Disapprove	316	35.8	57.0	7.2
Approve	1730	33.8	63.0	3.2
Discuss F.P with wives				
No	1154	33.3	62.6	4.1
Yes	893	35.2	61.5	3.3
Ideal number of children				
0-2	1318	35.0	62.8	2.2
3-4	555	32.4	63.8	3.8
5 or more	38	39.5	57.9	2.6
Non response	137	30.7	48.9	20.4

Background characteristics	Number of respondents	Want more	Want no more	Undecided
Ideal number of son				
0-2	1861	34.2	63.0	2.8
3-4	49	38.8	61.2	-
5 or more	138	30.4	49.3	20.3
Child loss experience				
No	1397	41.3	55.1	3.6
Yes	651	18.6	77.0	4.4
Religion				
Muslims	1761	34.6	61.6	3.8
Non-Muslims	287	31.0	64.8	4.2

Age of husband have linear relationship with their fertility desire. The result shows that the desire for no more children increases with age of men, from 19.7 percent of men aged less than 30, to 88.4 percent of them who are above 40.

Table 5.2 indicates that the currently married men both in urban and rural areas want no more children are in the same rate (about 62.0 percent). There is some regional variation in the desire for no more children. Sylhet division shows lowest level of desire for no more children (56.7) while Barisal division claimed the highest (66.5 percent).

Husband's education level shows very little effect on desire for no more children.

Occupation of husband has an important differential effect on desire for no more children. Men engaged in white collar jobs or self employed in agriculture are more likely to want no more children than men with other occupation.

Desire to have no more children is closely related to the number of living children and it increases as the number of living children increases (table 5.2). A man is more likely to desire for no more children if he has more living children. The proportion for desiring for no more children is approximately 1.5 percent who has no living children and it increases to 95 percent for the men who have 5 or more living children. Ideal

number of children has shown some differentials effect on fertility desire of husbands. As expected, desire for no more children decreases with the increase in the number of ideal number of children. Among the husbands who didn't give any numeric response only 48.9 percent of them want no more children. Ideal number of son has shown some differentials effect on fertility desire of husbands. Among the husbands who expect 0-2 son as ideal, about 63.0 percent of them want no more children compared to those who expect 3 or 4 son (61.2 percent). Among the husbands who expect 5 or more son as ideal, only 49.3 percent want no more children.

Husband's attitude towards family planning varies according to the fertility desire of them. Among the husbands who approve F.P 63.0 percent of them do not want more children compared to 57 percent of the husbands who do not approve F.P. Examination of the effect of family planning discussion with wives on reproductive desire in Bangladesh indicates that family planning discussion with wives is an important determinant of desire for another child or not. The men who have discussed about FP with their wives, 62 percent of them want no more children compared to 63 percent of those who never discussed with their wives about family planning. This indicates that the discussion about family planning with partner may help for limiting family size.

Experience of a child death is important predictor of reproductive desire. The result suggest that a strong association between child loss and desire for no more children. Among currently married men who have experienced of a child loss are more likely to limit their children than those who have not such a loss. Table 5.2 shows that 77.0 percent of respondents who lost a child want no more children compared to 55.1 percent of men who have not lost a child.

Currently married men who are Muslims are less likely to desire for no more children compared to those of other religions (62 percent vs. 65 percent).

Table 5.3: Percent distribution of desire for future child according to husband's and wife's report; BDHS, 1999-2000

Desire for more children	Husband's report	Wife's report
Have another	31.1	35.2
Wants no more	56.6	53.8
Undecided	3.5	2.2
sterilized	7.2	7.1
Declared infecund	1.6	1.7
Total	100.0	100.0
Number of men/women	2249	2249

Figure 5.1: Fertility preference of the couple.

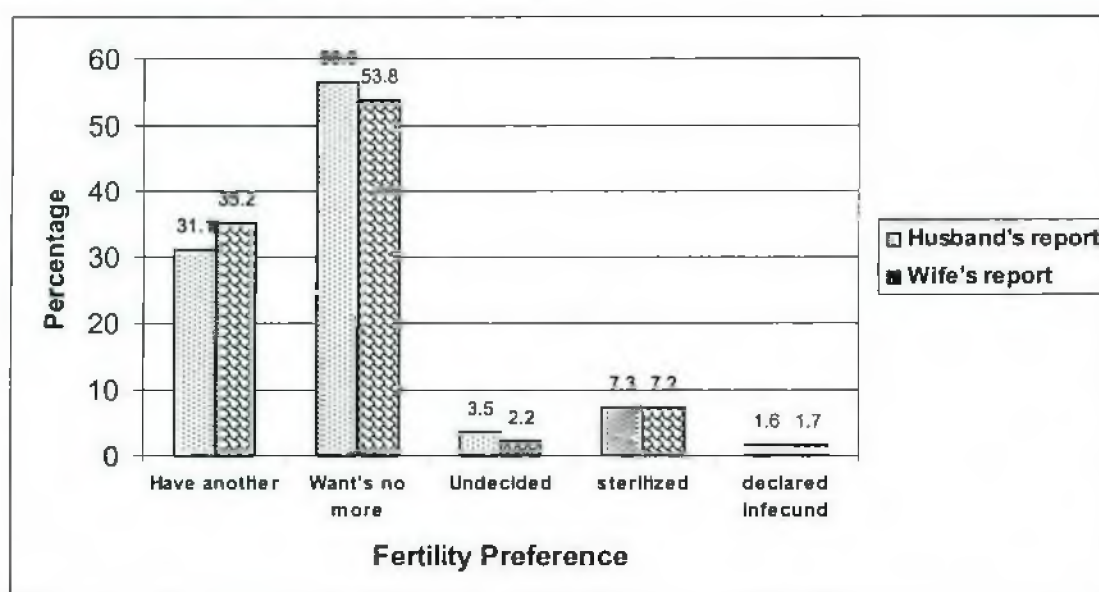


Table 5.3 and figure 5.1 shows the desire for future children according to husbands and wives report. The result indicate that husbands are less likely to want more children than their wives (31.1 percent vs. 35.2 percent) or husbands are more likely to want no more children than their wives (56.6 percent vs. 53.8 percent).

5.4 Couples Joint Fertility Desire and Number of Living Children

In this section, we have examined the joint fertility desires of couples by number of living children. The results suggest that fertility outcome follows the expected pattern in the two cases where the couples agreed and disagreed. However when the figures are desegregated by numbers of living children some differences emerge.

Table 5.4: Percentage distribution of couples by joint fertility desire and number of living children; BDHS, 1999-2000

Joint desire of fertility	Number of living children				Total
	0 child	1-2 children	3-4 children	5 or more	
Both want no more	0.5	37.0	81.1	89.2	57.0
Husband want no more, wife want more	3.5	12.0	6.6	6.2	8.5
Wife want no more, husband want more	2.5	7.0	6.4	2.9	5.6
Both want more	93.5	44.0	5.9	1.7	28.9
Total	100.0	100.0	100.0	100.0	100.0

Table 5.4 shows that 37.0 percent couples with (1-2) children reported that they want no more children and it is increase to 89.2 percent among couples with (5 or more) children who reported that they want no more.

5.5 Ideal Family Size

The BDHS also ask men how many children they would like to have. These questions pose a hypothetical situation for example, asking men who already have children, how many children they would have if they could start childbearing over again. As measures of their interest in family planning, therefore, men's responses to these questions are less reliable than those about reproductive intentions (Westoff, 1991; Bongaarts, 1990; Lightbourne, 1985; Tsui, 1985; Westoff, 1981).

Men's choice about ideal family size is a good indicator of their stance toward future childbearing, though their actual reproductive behavior may not confirm to their stated desires. Men's desire's for the ideal number of children are expressed in terms of the number of children, boys, girls and either sex. We also locate the ideal family size.

Table 5.5: Percentage distribution of ideal family size, according to husband's and wives; BDHS, 1999-2000

Ideal family size	Husband's report		Wife's report	
	Percent	Number	Percent	Number
Less than three	63.5	1429	64.0	1439
Three or four	27.7	624	31.2	703
Five or more	2.1	45	2.4	54
Non-numeric response	6.7	151	2.4	53
Total	100.0	2249	100.0	2249
Mean	-	2.4	-	2.5

Figure 5.2: Ideal family size expressed by couple

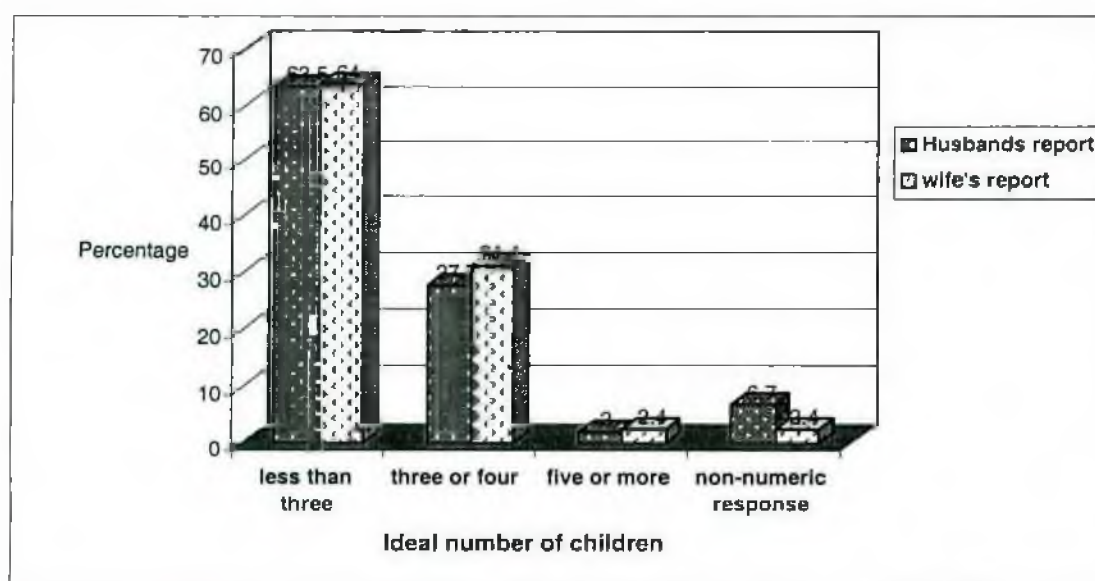


Table 5.5 and figure 5.2 shows the percentage distribution of ideal number of children for husbands and wives interviewed in the 1999-2000 BDHS. The table indicates the vast majority husbands (about 63.5) and wives (about 64 percent) want to have small families i.e. they consider less than three as ideal family size, while 27.7 percent husbands and 31.3 percent wives prefer to have three or more children. About 6.7 percent of husbands and 2.4 percent of wives gave identically a non-numeric answer such as “it is up to god,” “any number,” or “don't know”. Those who gave numeric responses generally want to have small families.

Table 5.5 also shows the percentage distribution of average family size for husbands and wives. The ideal family size as desired by husbands is lower than wives (2 vs. 3).

5.6 Factors Affecting the Desire for No More Children among Couples: A Multivariate Analysis

Logistic regression analysis is performed for identifying the factors affecting the desire for no more children.

Let Y_i denote the dependent variable for the i th observation. The logistic regression model was fitted by considering the want of no more children as a dependent dichotomous variable with,

$Y_i = 1$, if the i th respondents wants no more children

$Y_i = 0$, if the i th respondent want more children.

We fit the models based on husbands report on fertility preference. In the models we have considered 13 explanatory variables, which include socio-economic and demographic variables. According to husbands report out of 13 variables, 5 variables appeared to be significant factor determining husband's future fertility preferences. These are age of the respondents, region of residence, number of living children, ideal number of children and child loss experience. The remaining explanatory variables, namely the occupation of husbands, education of respondents, type of place of residence, family planning discussion with partner, religion, mass media exposure, ideal number of son and attitude towards FP do not seem to have significant independent effects on the desire for no more children.

Age of the respondents have significant relationship with couples fertility desire. Young husbands are less likely to want no more children than their older counterparts.

The divisional effect on desire for no more children is found to be an important one. The husband of Khulna division is 1.6 times more likely to want no more children

than those in Sylhet division. Husbands of Barisal, Chittagong, Dhaka and Rajshahi division do not differ significantly with the reference group (Sylhet division).

Table 5.6: Logistic regression of want no more children on some selected demographic and socio-economic factors among currently married husbands; BDHS, 1999-2000

Independent variables	Logistic coefficient (β)	S.E.	P value	Odds ratio
Age of the respondents				
<30	-1.055	.184	.000	.348
30-40	-.040	.1124	.745	.960
(40+)	-	-	-	1.000
Division				
Barisal	.178	.231	.454	1.194
Chittagong	.129	.205	.530	1.137
Dhaka	.230	.195	.238	1.259
Khulna	.446	.208	.032	1.562
Rajshahi	.175	.202	.386	1.191
(Sylhet)	-	-	-	1.000
Number of living children				
0	-5.570	.613	.000	.004
1-2	-1.899	.186	.000	.150
3-4	-.640	.171	.000	.527
(5+)	-	-	-	1.000
Ideal number of children				
0-2	1.182	.416	.0055	3.262
3-4	.469	.407	.250	1.598
Non numeric response	-5.534	22.242	.804	.004
(5+)	-	-	-	1.000
Child loss experience				
Yes	.247	.118	.037	1.28
(No)	-	-	-	1.000

Model chi-square :725.503

Degrees of freedom (df) :26

Probability :0.000

Note: FP= Family planning

: Reference category is in parenthesis

Number of living children is highly significant and appeared as one of the most important factor influencing the desire for no more children. The odds ratio for the number of living children shows that desire for no more children increases with the number of living children.

Ideal number of children is a significant factor for fertility desire. Desire for no more children decreases with the increase in the number of ideal family size. Husbands with ideal number of children 0-2 are 3.3 times more likely to want no more children compared to those with 5 or above children.

Child loss experience has a positive and significant effect on the desire for no more children. Husbands who have experienced child loss are 1.3 times more likely to want no more children compared to those who have no child loss experience.

Chapter Six

Men's participation in reproductive health care

6.1 Introduction

Male involvement does not just mean promoting the use of male method of contraception rather it means that men have a supporting role to play for their families in promoting gender equality, education of girls, empowerment of women, and share child rearing activities and sexuality (Verma, 1998).

Gender relations with the household have a strong influence in reproductive decision making and behavior. In developing countries where men are the ultimate decision maker, women have little say about reproductive process and also about contraceptive practice. Men's risky sexual behavior and irresponsible decisions make women vulnerable. Even sometimes women are not permitted to take decision about child care and child education. Women are facing domestic violence through physical torture and harassment. They have trouble talking about sex or mentioning reproductive health concerns.

Today it is given much emphasis on participation of men in providing women's reproductive health care for the betterment of both women and children. In addition it is admitted that men's greater responsibility about child care should be ensured to lead a healthy family. Women's reproductive health is divided into two stages-antenatal and post natal. Both two stages claim important and timely involvement of men. The chapter analyses men's knowledge, perception and attitude towards women's reproductive health care in Bangladesh in a very limited ways because of the non availability of data in DHS.

6.2 Men's Changing Role in Women's Reproductive Health

The historic focus for women has led to neglect of men's need for reproductive health information and services, often to the disadvantage of both men and women. Men are often less knowledgeable about anatomy and physiology than are women, but more reluctant than women to show their ignorance. A survey in India (Bloom, et al., 2000) and intervention study in Pakistan (Kamal, et al., 2001) each documented that even educated men lacked knowledge about reproductive health issues. Men have a right to and need for reproductive health information and services (Ringheim, 2002).

Table 6.1: Men's knowledge about the complicity of pregnancy experienced by woman: BDHS 1999-2000

Type of problem	Percent
Severe headache/blurry vision/swollen arms and legs	35.1
Vaginal bleeding during pregnancy	8.7
Labor more than 18 hours	38.8
Excessive bleeding	12.8
Convulsions	32.8
Fever more than three days	3.2
Bad smelling vaginal discharge	1.8
Others	18.6
Don't know	17.0
Total number of men	2556

Table 6.1 presents men's perception about the most frequent reproductive health problems that women face. Among the reproductive health problems, the most commonly known problem is long labor, as it is known by 39 percent of the husband, closely followed by severe headache/blurry vision/swollen arms and legs (35 percent), convulsion (33 percent), excessive bleeding (13 percent) and vaginal bleeding (9 percent).

Table 6.2 presents the differentials of men's knowledge about at least one complication during pregnancy by selected socio-economic and demographic factors.

Table 6.2: Percentage of husbands according to the complication of pregnancy known by them by background characteristics: BDHS 1999-2000

Background characteristics	Know at least one complication of pregnancy	No. of respondents
Age of the respondents		
<30	80.8	421
30-40	82.6	939
40+	84.8	889
Place of residence		
Urban	82.9	690
Rural	83.3	1559
Division		
Barisal	87.4	199
Chittagong	75.8	389
Dhaka	87.3	582
Khulna	77.0	404
Rajshahi	89.8	460
Sylhet	78.6	215
Respondents education		
No education	76.8	740
Primary	84.4	666
Secondary or higher	87.8	843
Respondents occupation		
Prof-tech-manag	85.4	692
Agri-self employed	83.1	581
Agri-employed	81.1	159
Skilled manual	83.7	283
Unskilled manual	80.1	457
Others	83.1	77
Religion		
Muslims	83.4	1939
Non-Muslims	81.6	310
Listen to radio		
Yes	85.9	1295
No	79.4	954
Watch T.V		
Yes	85.9	1451
No	78.2	798

Background characteristics	Know at least one complication of pregnancy	No. of respondents
Summary of the table		
Doesn't know	16.9	379
Know at least one complication	83.1	1870
Total	100.0	2249

Based on 2249 couples

Knowledge about the complication of pregnancy increases with the age of the husbands. There is no significant variation in men's knowledge about at least one complication of pregnancy between rural and urban areas (83.3 percent vs. 82.9 percent).

Knowledge of complication of pregnancy is much lower among the husband in Chittagong division while in Rajshahi division it is highest according to husband's report. Only 75.8 percent of husbands in Chittagong division and 89.8 percent of husbands in Rajshahi division reported themselves as they know at least one complication of pregnancy.

Men's knowledge of pregnancy complication increases with the level of education. 76.8 percent of husband knows at least one complication of pregnancy having no education. The proportion rises to 84.4 percent among husbands with primary level of education and it further increases to 87.8 percent among the husband with secondary or above level of education. Men's knowledge of complication of pregnancy is highest among the professionals.

Rate of knowledge of complication of pregnancy is slightly higher among Muslims than non-Muslim (83 vs. 82 percent).

About 86 percent of men who listen to radio know about at least one complication of pregnancy compared to 79.4 percent of those who don't listen to radio. About 86 percent of the men who watch T.V have knowledge about the complication of pregnancy compared to 78 percent of those who doesn't watch TV.

Proper antenatal care is essential for the safety of both mother and the coming child. The role of men as principle decision makers in antenatal care is to make all arrangements for the better treatment of pregnant women. Table 6.3 shows men's attitude towards women's antenatal care.

Table 6.3: Men's attitude towards women's antenatal health care: BDHS 1999-2000

Whether approves medical check-up	percent
Approves pregnant women having check if not sick	
Yes	81.1
No	15.5
Don't know	3.4
Time during the pregnant women should have first check-up	
First month	3.4
Second month	6.7
Third month	39.4
Fourth month	8.5
Fifth month	12.2
Sixth month	8.5
Seventh month	4.4
Eight month	2.3
Ninth month	0.7
Don't know	13.8
Wife receive antenatal care when she was pregnant	
Yes	48.4
No	50.3
Don't know	1.3
Wife given antenatal care by health professional	
Yes	17.1
No	82.9
Total number of men	2556

The results indicate that about 81 percent of the husband approve that women should go for check up during pregnancy even though women are not sick. About 39 percent of the husband reported that pregnant woman should have first check up during the third month of pregnancy. The figure gradually decreases over the increase in the month. Whereas only 48.4 percent of husband reported that their wives receive antenatal care. More frustrating results are found in the question whether women are given antenatal care by health professional. In this case 83 percent husband reports

that their wives are not given antenatal care by health professional. It is to be reminded here that in our sample 80 percent husband come from rural areas. Usually in rural areas education level of respondents is low and health care facilities are poor.

Figure 6.1: Whether women received antenatal care or not

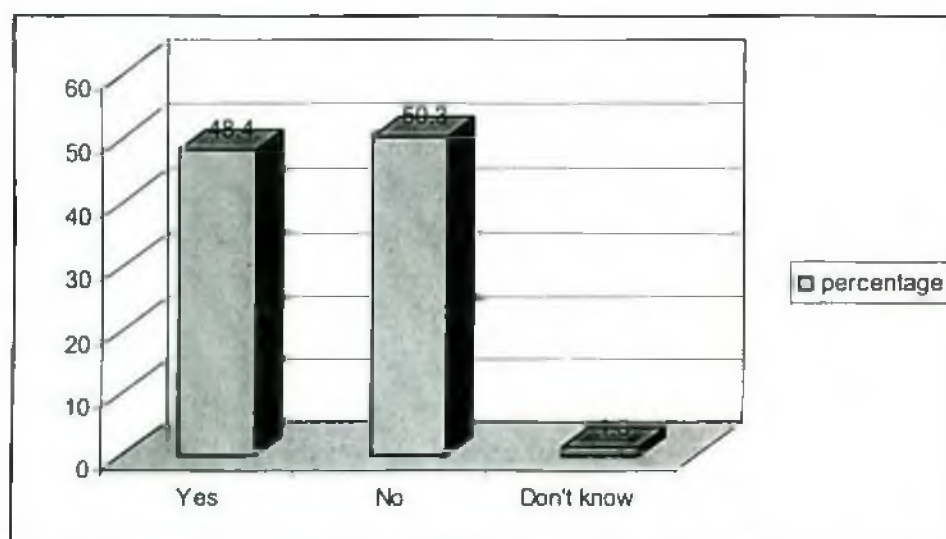
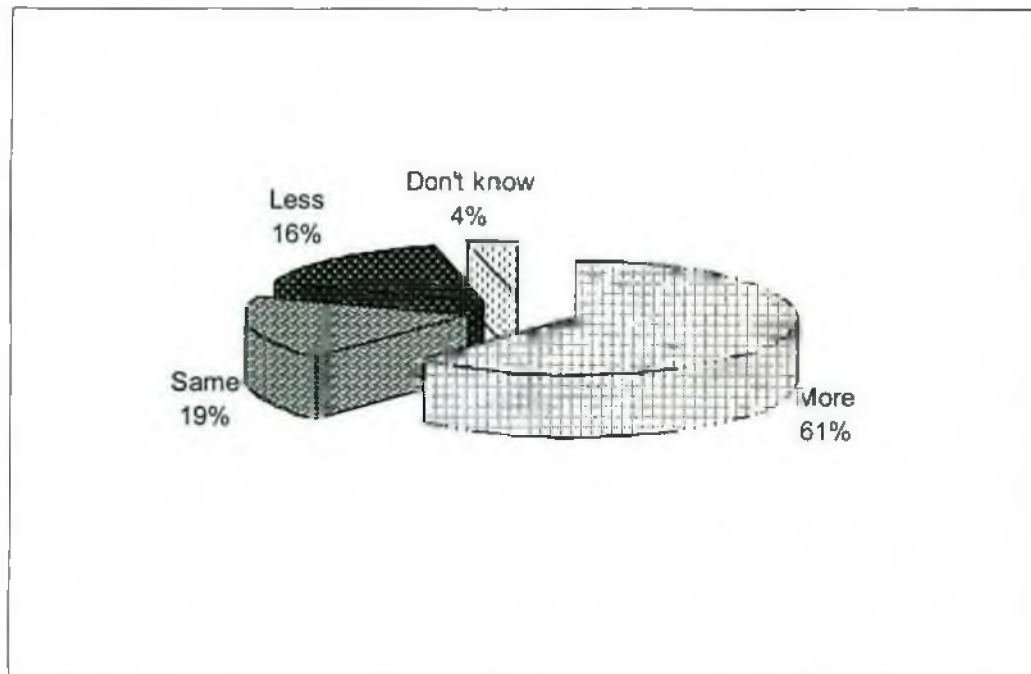


Table 6.4: Men's participation in women's reproductive health care: BDHS 1999-2000

Whether approves medical check-up	percent
Respondent present during the antenatal care visit	
Yes	53.0
No	47.0
Health professional talked to respondent about pregnancy	
Yes	37.0
No	63.0
Talked to wife about her own health and the baby's health	
Yes	61.2
No	38.8
Eating changes during pregnancy	
More	61.9
Same	18.5
Les	15.9
Don't know	3.7
Total number of men	2556

Table 6.4 presents the level of participation in women's reproductive health care by their husband. It is evident that slightly more than half (53 percent) of the husband were present at the time of their wives antenatal care visit. Men should also talk to health professional about the pregnancy related problems. But from our study we find that only 37.0 percent husband talked to the health professional. Balanced and improved foods having high nutritional values should be provided to pregnant women for keeping good health of mother and simultaneously for the child. 62.0 percent husband reported that their wives now eat more than previous time before pregnancy. This shows positive attitude of men towards health issue of pregnant women.

Figure 6.2: Changes in food taking behavior of women during pregnancy



6.3 Responsibility as a Father in Child Care

Men can become more involved in helping their children's healthy development for example, ensuring that their children receive all of the needed immunizations. Responsibility as a father should be maintained to lead a healthy family. Child's care is a must for a lively future life.

Table 6.5: Percent distributions of the men's responsibility about children: BDHS 1999-2000

Category	Percent
Present at birth	
Yes	70.7
No	29.3
Respondent took child to the health facility	
Yes	29.8
No	70.2
Child vaccinated	
Yes	87.4
No	10.2
Don't know	2.4

It is worrying to note that only 30 percent respondents took their child to health care center. To get immunization of their children is essentially a part of the job on the part of both father and mother to ensure safe future. In this study we find that 87 percent child were vaccinated which is encouraging. Awareness of father and mother is working behind this achievement. This also may be due to the initiatives undertaken by health workers of different government and non-government organization.

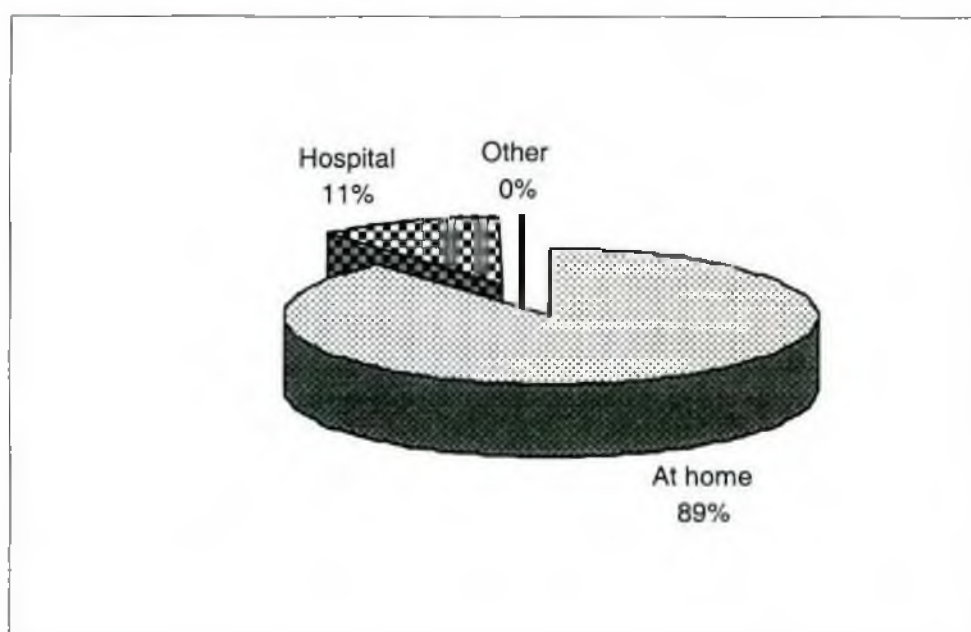
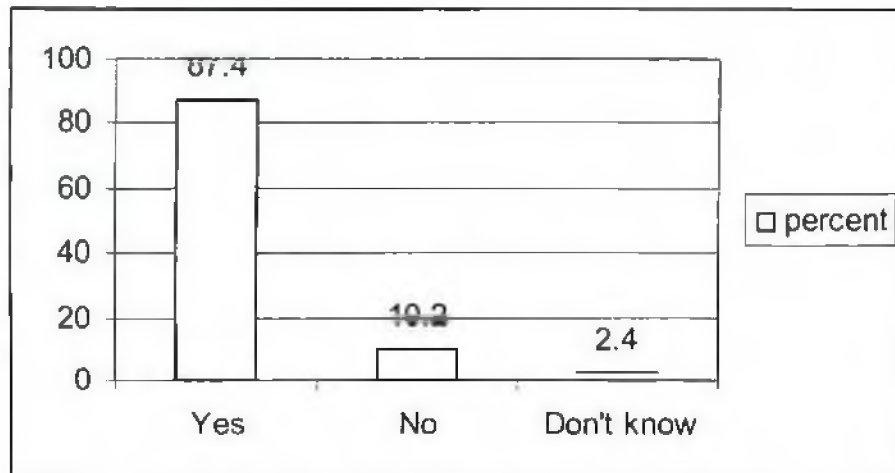
Figure 6.3: Place of delivery of the last child

Figure 6.4: Whether child vaccinated or not



6.4 Supportive Partnership:

Husband's support to their wives for using family planning methods takes different forms, such as giving approval to using contraception, taking care of their wives during pregnancy, providing information which may be more easily accessible to males due to their greater mobility i.e. discussion about family planning with wives. Thus we can make our dependent variable supportive partnership of male by combining the following three variables.

- Husbands approve FP
- Discuss FP with wives
- Husbands take care of their reproductive health

Husbands Approve FP

Male attitude towards family planning in Bangladesh is generally positive. Bangladeshi men appear to be as interested as partners in small family size, regardless of residence, education, or age. Even in Sylhet where the national family planning program had the lowest contraceptive prevalence rate in 1999-2000, about 69 percent of husbands' approval of family planning. The impact of husband wife communication was investigated among 2249 husbands of reproductive age in BDHS 1999-2000. It showed that about 85 percent husbands approve their wives use family planning and about 15 percent husbands disapprove their wives use family planning.

Discuss FP with Their Wives

From the BDHS 1999-2000 data we saw that the percentage of husbands who discuss about family planning with their wives and the percentage who does not are almost equal (49.6% vs. 50.4%).

Husbands Take Care of Their Reproductive Health (R.H.)

From the table 6.6 we see that only 89.4 percent husbands take care of their wives. Although the figure is based on 2074 husbands who have child, we found that 1854 respondents either think that women should have a medical check-up when they are pregnant even they are not sick or present during the antenatal care visit or talked with wife about own/ baby's health or present at the time of birth or took child to the health facility for immunization.

Table 6.6: Percentage distribution of husbands who have children and take care of their wife: BDHS 1999-2000

Husband's take care of their R.H.	Percent	Number
No	10.6	220
Yes	89.4	1854
Total	100.0	2074

Thus we have created our dependent variable supportive partnership by combining the above three variables. The frequency distribution of this variable is given below:

Table 6.7: Percentage distribution of husbands by supportive partnership: BDHS 1999-2000

Supportive partner	Percent	Number
No	55.3	1146
Yes	44.7	928
Total	100.0	2074

6.5 Differentials in Supportive Partnership

Differential in supportive partnership of men are examined here in order to identify those subgroups that may be particularly successful in using male contraceptive methods and second, the broader set of programmatic and non-programmatic factors, which influence contraceptive behavior. The following variables are included in the differential analysis, undertaken in this section: age, place of residence, division, education of the respondents, occupation of the respondents, religion, current use of contraception, ideal number of children, ideal number of son, exposure to mass-media, desire for more children, number of living children.

Table 6.8: percentage distribution of husbands being a supportive partner by background characteristics: BDHS 1999-2000

Background characteristics	Percentage of supportive partnership of male	No. of respondents
Age of the respondents		
<30	57.4	298
30-40	52.0	895
40+	33.1	881
Place of residence		
Urban	46.2	625
Rural	44.1	1449
Division		
Barisal	54.3	188
Chittagong	41.4	365
Dhaka	46.1	531
Khulna	43.1	369
Rajshahi	49.1	422
Sylhet	32.2	199
Respondents education		
No education	36.5	695
Primary	42.4	616
Secondary or higher	54.1	763
Respondents occupation		
Prof-tech-manag	48.8	642
Agri-self employed	40.7	548
Agri-employed	45.3	150
Skilled manual	49.0	245
Unskilled manual	42.1	423
Others	39.4	66

Background characteristics	Percentage of supportive partnership of male	No. of respondents
Ideal number of children		
0-2	49.6	1290
3-4	41.1	598
5+	22.6	186
Religion		
Muslims	44.5	1788
Non-Muslims	46.2	286
Number of living children		
0*	38.5	26
1-2	51.9	939
3-4	42.9	700
5+	32.0	409
Currently using contraception		
No	30.1	675
Yes	51.8	1399
Fertility preference		
Have another	53.3	531
No more	45.5	1269
Undecided or others	24.5	274
Summary of the table		
Supportive partner	44.7	928
No	55.3	1146
Total	100.0	2074

Based on 2249 couples

*ever had children

Supportive partnership of male varies according to the age of respondents. Young husbands are more likely to be supportive to their wives than older husbands.

Supportive partnership of husbands varies slightly by place of residence. The level of supportive partnership is slightly higher in urban areas than in rural areas (46.2 percent vs 44.1). Supportive partnership of male is much lower in Sylhet division while in Barisal division it is highest according to husbands report. Only 32.2 percent in Sylhet division and 54.3 percent of husbands in Barisal division reported themselves as the supportive partner of their wives in family planning process.

Supportive partnership differs by educational level of the husband. Moral support of husbands increases with the educational level. While 36.5 percent of husbands having no education are participating in family planning indirectly by giving moral support to their wives, the proportion rises to over 42.4 percent among husbands having some primary education. Among those husbands with education secondary or higher level, this rate rises further, reaching a high of around 54 percent.

Supportive partnership varies according to husband's profession. Husbands having profession skilled manual or 'prof-tech-manag', are more likely to be supportive to their wives in practicing family planning compared to the husbands with other professions.

Husbands with small family size of 1-2 children are more likely to be supportive to their wives compared to husbands with larger families or no child family. Ideal family size has negative relationship with husband's supportive role. Husbands' supportive role decreases with the family size.

The desire for more children is the variable which can provide the information regarding fertility preference. Desire for more children have great influence on supportive role of men. From the table we have seen that about 53.3 percent of husbands who wants more children support their wives to use family planning methods, this rate decreased to 45.5 percent when the husbands want no more children.

The current use of contraception has shown great differentials on supportive partnership of husbands. Contraceptive users play more supportive role than non-users.

Rate of supportive partnership is slightly higher among non-Muslims than Muslims. In the BDHS 1999-2000, 46 percent of non-Muslims and 44.6 percent of Muslims act as a supportive partner of their wives.

6.6 Determinants of Husbands Supportive Role

This section presents the results of the logistic regression technique used to identify the factors affecting the rate of supportive partnership among the husbands.

Logistic regression analysis shows that among the husbands the significant variables are the respondent's age, region, respondents education, partners education, fertility preference, current use of contraception,. The remaining explanatory variables are ideal number of sons, type of place of residence, religion, ideal number of children, number of living children, exposure to mass media, husbands occupation and child loss experience do not seem to have significant independent effects on the supportive partnership of husbands.

Table 6.9: Logistic regression of supportive partnership on some selected demographic and socio-economic factors among currently married husbands; BDHS, 1999-2000

Independent variables	Logistic coefficient (β)	S.E.	P value	Odds ratio
Age of the husbands				
<30	-.697	.120	.000	.498
30-40	.221	.156	.156	1.248
(40+)	-	-	-	1.000
Division				
Barisal	-.363	.200	.069	.695
Chittagong	.164	.191	.392	1.178
Dhaka	-.230	.160	.150	.794
Khulna	.016	.142	.909	1.016
Rajshahi	-.379	.154	.014	.685
(Sylhet)	-	-	-	1.000
Education of the husbands				
(No education)	-	-	-	1.000
Primary	-.360	.148	.015	.698
Secondary or higher	-.242	.138	.080	.785

Independent variables	Logistic coefficient (β)	S.E.	P value	Odds ratio
Fertility preference				
Want another	-.845	.162	.000	.430
No more (Undecided or others)	.048 -	.135 -	.722 -	1.049 1.000
Current use of contraception				
Yes (No)	.898 -	.112 -	.000 -	2.454 1.000
Education of partner				
(No education) Primary Secondary or higher	- -.608 -.209	- .155 .146	- .000 .151	1.000 .544 .811

Model chi-square :315.808

Degrees of freedom (df) :29

Probability :0.000

Note: FP= Family planning

*ever had children

: Reference category is in parenthesis

Age of the husbands have significant effect on the supportive partnership. Young husbands are less likely to be supportive to their wives than their older counterparts.

For different division the rate of supportive partnership among husbands is different. The husband of Chittagong and Khulna division is respectively 1.18 times and 1.02 times more likely to supportive to their wives than those in Sylhet division. Husbands of Barisal division, Dhaka division and Rajshahi division do not differ significantly with the reference group (Sylhet division).

The education of the husbands and his partner has significant effect on the supportive partnership. Moral support increases as the rate of education increases.

Fertility preference is a highly significant factor for the supportive role of husbands. Among the husbands those want no more children differ significantly with the reference group (undecided or others) and they are 1.049 times more likely to be supportive to their wives.

Current use of contraceptive method is closely and positively associated with the supportive role of husbands. The regression coefficient (.90) is highly significant which indicates that husbands those are using any contraceptive method are more likely to be supportive partner. Husbands those are using contraceptive method are 2.454 times more supportive to their wives than those who are not currently using any method.

Chapter Seven

Men's Knowledge and Awareness about AIDS and Other STDs

7.1 Introduction

The world's most pressing reproductive health problems are Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) and other sexually transmitted diseases (STDs) which have no cure. The acquired immune deficiency syndrome (AIDS), sometimes called as a fatal illness caused by a retrovirus known as the human immunodeficiency virus (HIV), which breaks down the bodies immune system, neurological disorders, sum of which then become the direct cause of death. It is the most dangerous communicable disease human community have ever faced.

A recent study in Zambia indicates that HIV/AIDs gradually influenced women and men's childbearing and contraceptive use decisions. The study also demonstrated that HIV/AIDs have increased the burden of caring for children whose parents have died of AIDS (Rutenberg et al., 2000).

The joint United Nations Programme on HIV/AIDS (UNAIDS) World campaign focused in 2000 and 2001 on involving men, particularly young men. The agency says that more than 70% of HIV infections occur as a result of heterosexual intercourse and an additional 5-10% through sex between men (Piot, 2001). According to the UNAIDS, 'men are key too in reducing HIV transmission and have the power to change the course of the AIDS epidemic (Raju and Leonard, 2000).

In Bangladesh, Government has formed a task force and the National Aids Committee (NAC) to formulate the national policy on HIV/AIDS and STD related issues. According to the policy, the STD programme will focus on the promotion of safer sexual behaviors and supply of condoms; case management throughout the public and private general health system, including first level health care; the use of simple

algorithms based on syndromic diagnosis; the inclusion of STD care in MCH services; the targeting of STD care services to population identified as at an increased risk ; and the promotion of STD related and other sexual health care- seeking behavior-related education. Efforts to increase clinical contraception include the promotion of vasectomy services (DGHS, 1996).

In many developing countries, particularly in African countries, spread of HIV/AIDS becomes a fatal disaster. In South Asian countries like India four millions of people have infected from these diseases. Although AIDS is not widespread in Bangladesh, but Bangladesh is not totally free from this fatal disease. According to national AIDS committee report at least 20,000 are carrying HIV and a total of 102 people have so far died of AIDS in Bangladesh (The Daily Star, 1998).

Prevention is the only solution to get rid of HIV/AIDS and STDs. Preventive measures are the safer sexual behavior, avoiding sexual relationship with multiple partners, bringing change in the cultural norms, use of contraceptive methods like condom etc. Raising awareness among men about the long run effect of these diseases is one of the prime objectives of reproductive health programs currently executing in the world. Our study pay's attention to get an idea of men's perception about these types of reproductive health problems. Two separate sections will cover men's knowledge about HIV/AIDS and STDs respectively and also about ways to avoid these diseases.

7.2 Men's Knowledge and Perception about HIV/AIDS

Acquired immune deficiency syndrome (AIDS) is an illness caused by the human immunodeficiency virus (HIV), which weakens the immune system and leads to death. The virus is generally transmitted through sexual contact, through HIV-infected women to their unborn children, or through contaminated blood and needles. HIV and AIDS prevalence is not yet widespread in Bangladesh. Although Bangladeshi society is in general close and conservative, it is highly prone to the health hazard due to HIV/AIDS infection, because the prevalence of HIV/AIDS is

quite high in the neighboring countries India and Myanmar. One of the most important strategies for reducing the rate of HIV/AIDS infection is the promotion of accurate knowledge of AIDS and how it is transmitted and how to prevent transmission.

Table 7.1: Percentage distribution of currently married men and ever-married women according to their knowledge of HIV/AIDS and valid ways to avoid HIV/AIDS, and communication with spouse about AIDS Bangladesh 1999-2000

Knowledge of HIV/AIDS	Men	Women
Ever heard of HIV/AIDS	50.2	30.8
Knowledge of valid ways to avoid AIDS:		
Knows HIV/AIDS but doesn't know of valid way	23.1	17.3
Knows only one valid ways	9.2	6.3
Knows two or more valid ways	18.0	7.2
Does not know HIV/AIDS	49.8	69.2
Total	100.0	100.0
Number	2,556	10,544
Talked to wife about preventing AIDS		
Yes	21.6	24.4
No	78.0	75.2
Don't know / Missing	0.4	0.4
Total	100.0	100.0
Number	2,453	3,058

The BDHS included several questions on AIDS in order to assess knowledge about AIDS, its transmission and prevention mechanism. The information was collected from both men and women. The results indicate poor knowledge about HIV/AIDS among the married men and women. Only 31 percent of women and half of men ever heard of HIV/AIDS, which indicates higher knowledge of HIV/AIDS among men than women (table 7.1). Of the 50 percent men who know about HIV/AIDS, 27 percent (i.e. slightly more than half who knows about AIDS) have effective knowledge as they about one or more valid ways to avoid AIDS. The corresponding figure for women is only 13.5 percent and 44 percent respectively. Table 7.1 also shows that 22 percent of men and 24 percent women talked to their spouses about the prevention of AIDS.

Figure 7.1: Knowledge of valid ways to avoid HIV/AIDS

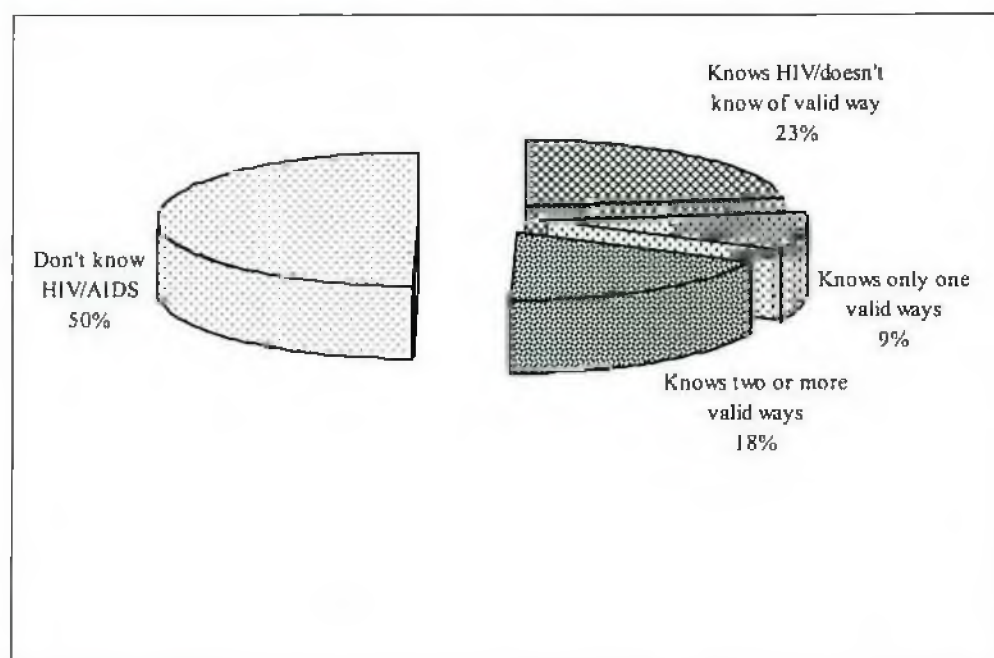


Table 7.2: Percent distribution of men who have heard of AIDS by perception of AIDS and sources of information about HIV/AIDS: BDHS 1999-2000

Heard of AIDS	Men	Women
Can a healthy person have AIDS		
Yes	66.2	68.3
No	17.4	13.6
Don't know/missing	16.4	18.1
Total	100.0	100.0
Sources of AIDS/HIV information		
Radio	22.7	10.2
TV	33.0	21.5
Newspaper/magazines	18.1	4.6
Pamphlets/poster	5.5	1.7
Health workers	7.1	2.6
Mosques/temples/churches	0.2	0.0
Schools/teacher	0.4	0.2
Community meetings	1.4	0.5
Friends/relatives	19.3	11.6
Work place	3.6	0.5
Other sources	2.9	0.6
Mean number of sources	2.3	1.7
Total men / women	2556	10544

More interesting figure is found from the table 7.2 which reveals that a substantial proportion of men are ignorant about AIDS. Respondents were asked whether a

healthy person can have AIDS or not. To answer this question 66.2 percent men and 68 percent women said yes, which is a completely wrong idea. Table 7.2 also shows the percentage of respondents who have heard of AIDS from specific sources. Television is the most important source of information about AIDS. Nearly 23 percent men and 10 percent of women have got idea about HIV/AIDS from radio and 33 percent men and 21.5 percent women from TV. Newspapers (18.1 percent for men and 4.6 for women) and friends and relatives (12 percent for women and 19 percent for men) are other major source of getting information about these diseases.

Emphasis is given on making knowledge how to avoid HIV/AIDS as there is no cure to get rid of the unbearable sufferings from these diseases. Some idea about the preventive measures to avoid HIV/AIDS is already examined. Men's indiscriminating sexual behavior is the prime cause of the occurrence of HIV/AIDS. So to bring change in developing healthy sexual relationship is essential for preventing these diseases.

Table 7.3: Percentage distribution of men's knowledge about the ways to avoid AIDS/HIV: BDHS 1999-2000

Ways to avoid AIDS	Men
Abstain from sexual relation	2.4
Use condom	17.9
Avoid multiple partners	12.1
Have only one sex partners	9.4
Avoid sex with prostitutes	40.8
Avoid sex with homosexuals	2.1
Avoid transfusion	1.9
Avoid injection	10.8
Avoid sharing razors/blades	2.4
Avoid kissing	1.0
Avoid mosquito bites	0.4
Seek protection from traditional healer	1.2
Other	24.2
Don't know specific way	7.2
Doesn't know if AIDS can be avoided	25.2
Believes no way to avoid AIDS	10.5
Total number of men who know AIDS	1,284

The table 7.3 is giving the data regarding men's knowledge about the ways to avoid HIV/AIDS. It is seen that the way like avoid sex with the prostitutes is known by a

large portion of men (40.8 percent). The ways like avoid multiple partners and use condom are the next that are frequently known to men, 17.9 and 12.1 percent respectively. 25.2 percent men don't know how to avoid AIDS. This is relatively high figure.

7.3 Perception about STDs

During the past several years, only a few studies have been carried out on sexual behaviour of men, describing male involvement in pre and extra marital sex and their experience with STDs. Limited information is available concerning where men go for diagnosis and treatment of STDs, treatment of perceived sexual dysfunction or urological problems. The programme managers of most service providing organizations tend to think of reproductive health simply as a set of preventive measures, diagnosis, and treatment of RTIs (reproductive tract infections) and STDs (Pelon, 1996).

Perception about sexually transmitted diseases mentioned above is essential, alongside the knowledge about AIDS, to lead a safer life. Ultimately it will keep the society more safe and healthy. But unfortunately, 81.2 percent men have no idea about STDs as observed from the table 7.4, a small percentage of men know any symptom of STDs, 3.8 percent know only one symptom and 8.7 percent know any two symptoms.

Table 7.4: Percent distribution of respondents by their knowledge of STIs (other than HIV/AIDS): BDHS 1999-2000

Knowledge of specific sign and symptoms	Men
No knowledge of STIs	81.2
Does not know any symptoms	6.3
Knows one symptom only	3.8
Knows two or more symptoms	8.7
Total	100.0
Total number of men	2556

We want to know what proportion of men is aware of different signs usually found in both infected men and women. The signs like discharge from penises, foul smelling

discharge, burning pain and genital sores are the signs of STDs found in men that are frequently known to men. Men's perception is also higher in case of signs like genital discharge, foul smelling discharge, urination and ulcers found in women.

Figure 7.2: Knowledge of specific signs and symptoms of STIs

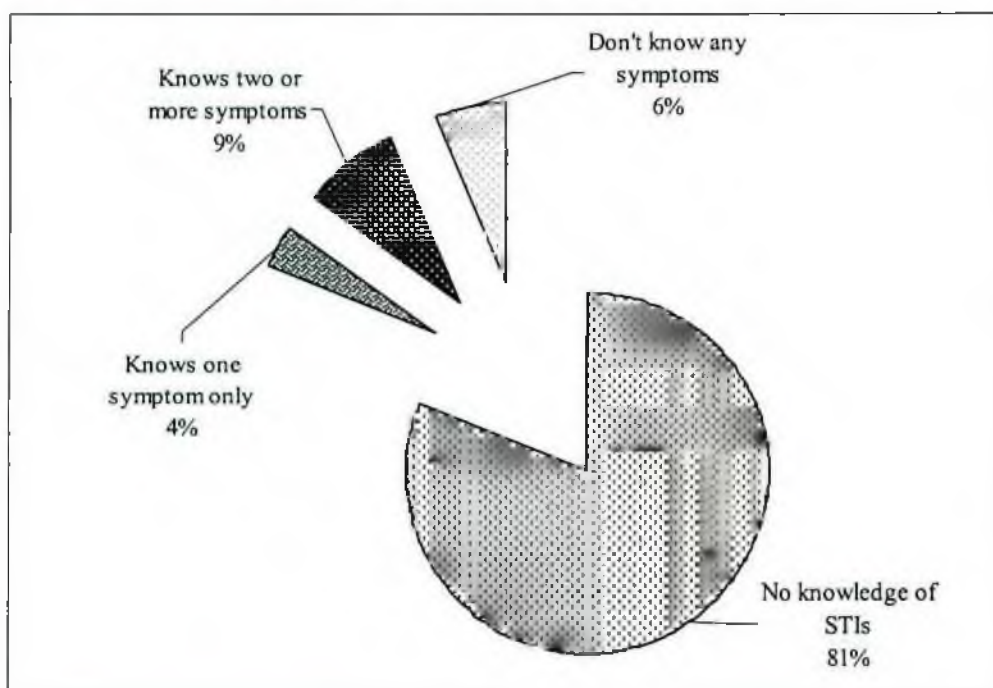


Table 7.5: Percent distribution of respondent by knowledge of signs and symptoms associated with sexual transmitted diseases: BDHS 1999-2000

Respondent knowledge of sign and symptoms	Sign of STDs of a men	Signs of STDs of women
Lower abdominal pain	4.1	7.3
Discharge from penis/genital discharge	21.4	19.6
Foul smelling discharge	34.7	27.7
Burning pain or urination	22.6	18.1
Redness/in flammation in genitals	9.0	8.7
Swelling in genital area	14.5	12.2
Genital sores/ulcers	48.3	42.9
Genital warts	11.0	10.2
Blood in urine	9.7	9.3
Loss of weight	9.9	7.7
Impotence/inability to give birth	4.7	5.0
No symptoms	0.0	0.0
Other	4.1	11.7
don't know	18.0	29.7
Total men /women	617	617

Chapter Eight

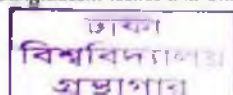
Discussion, Policy Recommendation and Conclusion

8.1 Discussion

This study covered two important areas of reproductive health of both men and women and analysed men's involvement and association in these areas. One is concerned about men's knowledge, attitude and practice of contraceptive in Bangladesh and other is about health matters of men, women and children. Men's perception about contraception and practices are the key issues on which we gave focus in this study. As well as we tried to bring the influencing factors in this regard. Getting idea about men's knowledge regarding AIDS and some STDs was the coherent area in this study to clarify reproductive health behaviour of men. Health care of pregnant women and of child is an important aspect to enhance men's role.

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The study reveals that knowledge and approval of family planning among men is very high in Bangladesh. Virtually all currently married men and women know at least one modern method of family planning. However, method specific knowledge varies from as low as 24 percent for Norplant to nearly 100 percent for pills among men. Men are less likely to know about the Norplant, IUD, withdrawal and male sterilization indicating the needs for campaign to increase men's knowledge about these methods for further increase in use of family planning methods and their effective use. Men in Bangladesh have positive attitude about small family size and they seem to support the use of contraceptive methods by their wives to regulate the fertility. But they are less willing to take the responsibility of using contraceptive methods. Only a small proportion of men (4.8 percent) are using modern male methods; 4.3 percent are using condoms and less than one percent are using vasectomy. Although condom using rate is rising slowly, vasectomy shows a declining trend. On the other hand traditional methods show increasing trends. Due to low age at marriage for females and early start of child bearing, many women reach to their desired family size within their thirties. These couples are not accepting permanent methods; rather they continue to use modern temporary methods such as pills or traditional methods. In some cases,



women may seek to adopt a contraceptive method without consulting their partner. As a result they often get pregnant and seek pregnancy termination in a harmful way, which often results in maternal mortality and morbidity. Policy makers and programme manager should aware of this type of practice and make services accessible to these couples.

The study confirms that the attitude towards family planning and fertility preference of the husband are more important in determining the couple's adoption of contraception than the wives attitude and preference. The finding that discussion between partners was an important explanatory factor in current contraceptive use shows that husbands, too, have a role in the adoption of contraception. Seventy two percent of couples reported that they had discussed issues regarding family planning with their spouses and contraceptive use was nearly two times higher among the couples who had discussed issues regarding family planning. Similar findings were reported in many other studies in Asia and African countries (Lozare, 1976; Ezeh, 1991; Nyblade and Menken, 1993; Petro-Nustas, 1999, Bankole and Singh, 1998). However, it does not necessarily mean that couples reach a decision together, because men in Bangladesh (as in most other Asian and African countries) are seen as the main decision-makers in the family.

Wife's reproductive preference also comes out as one of the significant factor of contraceptive use. This finding has implication for fertility and family planning behaviour. It implies that married women probably have better understanding of the benefit of spacing their children and danger associated with having more birth or births in quick succession than their husband have. Therefore, contraceptive use either to space or to limit family size is likely to be initiated by wives rather their husbands. But success in achieving a smaller family will depend on how responsive husband's fertility preferences and on the influence of husbands preferences on couples reproductive behaviour.

An effective way of increasing men's role in contraception is to increase women's empowerment through economic participation. In our country women are usually to take more responsibility of using contraceptive methods. Inherently women fall

victim of facing any side effects which cause disparity. Our study took the matter with due importance. We observed that men didn't prefer to allow women to go outside the house for income generating purposes. About 72 percent men opined that if they were able to provide enough money for family expenditure they would not allow women to work outside the house. Physical abuse is a common event in our country, particularly in rural areas. Nearly 36 percent respondent told that women should be beaten up by them for some specific reasons. This indicates their rude nature and attitude towards women. Along with this, it should be mentioned here that 64 percent men didn't agree with any specific reasons. This is a good indication.

To realize the demand of more active and meaningful participation of couples in contraception, a more dynamic family planning programs and strategies should be developed. Contraceptive practice of men can not be enhanced unless knowledge and perception about available methods, modern and traditional, are not increased. Programs should be target oriented to raise awareness among men about contraceptive methods. More importantly confusion and fear about modern methods should be removed from men. The comparative figures of contraceptive practice between men and women showed a large disparity. The finding of significant divergence between husbands and wives report on the husbands attitude toward family planning supports the results of research elsewhere in Asia and Africa (Bankole and Singh, 1998). This lack of knowledge may have important implications for contraceptive use.

Fertility preference of men is an important indicator of men's decision about participation in contraception. More than half of husbands (57 percent) have no desire for any more children, which is higher than that of wives. More than 60 percent respondents choose the ideal family size having number of children two. This is a good indication of future possibility of men's participation in contraceptive use. The mean number of children in this case is 2.41.

Women's health care issue in today's world is the most important concern of all as they bear the major health hazards during pregnancy. To protect and ensure safety of women's lives, men's association in terms of increasing perception about the problems pregnant women usually face is needed. Men's responsibility is important

during the pregnancy period. In this study we found men are not playing due role in providing health care to women. 83 percent respondents reported that their wives were not given antenatal care by health professional. Men's performance in case of providing child health care is low. 89 percent respondent reported that the place of delivery of the last child was at home and 70 percent didn't take their child to health care facility. But vaccination rate of their children is high. It is enthusiastic.

Men's effective knowledge about AIDS and other sexually transmitted diseases should be widened for the sake of avoiding future health hazard. Participation of contraceptive methods can be increased through enhancing knowledge about these non-curable diseases. According to the 1999-2000 only 50 percent men have heard of AIDS and comparatively women were found less aware of AIDS. Only 19 percent men are found aware of STDs. This indicates men's carelessness about these diseases.

8.2 Obstacles to Man's Participation

A careful review of the existing literature in Bangladesh and from other developed and developing countries suggests many factors responsible for a large gap between the rhetoric promoting male involvement and the reality of female-oriented reproductive health programmes. The major obstacles that men face in participating more in reproductive health are as follows:

Individual barriers

- Expectations about reproductive health that differ from program, or service offerings.
- Bias against service providers or authorities on reproductive health matters.
- Lack of motivation to become clients.
- Negative attitudes towards reproductive health care.
- Less priority to prevention than to curative care.
- Poor understanding of their reproductive health roles
- Low priority toward family planning or maternal and child health among young men.
- Little knowledge of contraceptive methods.

- Lack of enthusiasm to share reproductive health roles with wives.
- Health concerns about using contraceptives
- Outright refusal to use condoms.
- Acute lack of support for spouse using modern contraception
- Reluctance to seek treatment.

Social and cultural barriers

- Strong misconceptions about men's reproductive health needs.
- Reproductive health roles seen as women's business.
- Class differences between service providers and men.
- Failure of service providers to understand the culture.
- Community disinterest in seeking reproductive health services.
- Misconceptions and rumors about male methods- vasectomy and condoms.
- Lack of channels at various levels to reinforce reproductive health messages
- Low literacy rates or little educational attainment
- Cultural stereotypes against male contraceptive methods.
- Lack of motivation among service providers and community-based distributors.
- Limited number and range of communication media.

Institutional and Organizational Barriers

- Insufficient information about men's reproductive health needs
- Untrained personnel about men's reproductive health needs
- Underfinanced institutions, from central to district levels
- Negative staff attitudes and behavior toward men at service delivery points
- Lack of common terminology on men's reproductive health
- Lack of knowledge about man's expectations.
- Inadequate and inconsistent communication about reproductive health
- Mass-media messages that do not address young men's interests.
- Ineffective program management and lack of team work.
- Little or no involvement of opinion leaders-traditional, religious etc.
- Limited contraceptive options for men.
- Inadequate training of service providers in STDs and HIV/AIDS counseling.

- Insufficient provider knowledge about men's reproductive goals histories.
- Inadequate follow up plans from the service provider.
- Untrained personnel, especially among community service providers.
- Lack of basic equipment in most service delivery sites
- Gender issues not adequately integrated in programs.

Policy barriers

- Low priority to financing communication program for men.
- Weak coordination of men's issues at various levels.
- Strong pronatalist beliefs and politics
- Over centralization of program activities.
- Lack of political commitment or policy support.
- Promotional restrictions on surgical contraceptive methods
- Restrictive policies and of standards of reproductive health services.

8.3 Strategic Plan to Increase Male Involvement

To increase men's participation in reproductive health programme following strategic plan and policy could be undertaken.

1. Overcoming Obstacles, Encouraging Participation

Most people who have studied the subject agree that the two major avenues to increasing men's participation are communication and advocacy. Through better communication, including a focus on men's and women's social roles-gender issues-and through advocacy efforts, men can become more aware of reproductive health care, service providers can become better able to reach men, and national leaders (most of whom are men) can do more to support reproductive health care.

2. Information, Education and Communication for Men

Since the 1960s IEC (Information, Education and Communication) has played a powerful and growing role in making family planning a household word and a community norm. Since the HIV/AIDS epidemic began over a decade ago, IEC effort have been the main line of defense against the spread of this disease by promoting use

of condoms and by stressing the importance of sexually responsible behaviour. Particularly since the international conference on population and development (ICPD) in 1994, which called attention to men's role in reproductive health, there has been growing attention to IEC for men's participation.

A well designed male focused community-based IEC activity aiming at improving men's knowledge about reproductive health issues and services, increasing the use of reproductive health services by men, increasing supportiveness of husbands for the reproductive health of their wives and preventing STDs/AIDS should be undertaken. IEC interventions should be directed to use social elite, such as, Union Parishad (UP) Chairmen, UP members, school teachers, other informal and formal leaders, interested religious leaders and popular village practitioners to promote the issues of reproductive health and the responsibility of men.

3. Encouraging Communication between Spouses

Men can support women's choices better when couples can talk about reproductive health and family planning. Family planning communication campaigns can change men's role in contraceptive decision making.

4. Entertainment-Education Approach

Men's attention can be attracted by using an entertainment format-the 'enter-educate' approach- which has proved effective in many countries. The term inter-educate is a contraction of the words entertainment and education and describes any communication presentation that delivers a pro-social educational message in an entertainment format.

5. Communication in the Context of Service Delivery

Communication and service delivery go hand in hand. People will not be able to use reproductive health services unless they know about them. Once people are motivated to improve their reproductive health, by using family planning methods, for example, they need information and counseling about appropriate methods, correct use, side effects, and the concerns that most people have about adopting new practices.

As service providers and communicators reach out more to men and their partners, they must learn more about their client's information needs and how to provide counseling for men. Often service providers will need new training in counseling men; informational materials, such as leaflets, posters and flipcharts, will need to be prepared for men. Also, as communication and advocacy efforts create more demand for reproductive health services among men, programs will need to insure that the expectations of clients are met with a commensurate increase in services.

6. Services for Men

The AVSC international developed a model which is an extensive list of all possibilities for service delivery planners to consider in planning and implementing reproductive health services for men. The model consists of three main areas: screening-a medical history to be obtained from every men who comes to the clinic; information and counseling – to be provided to every men who visit the clinic; and clinical services – to be provided if the need is identified in screening.

7. Designing Convenient, Appealing Services

Men can not share the responsibility for reproductive health and family planning services and information do not reach them. Few men go to facilities that offer services primarily for women. Men must be reached in other ways. In this regards, following approaches may be adopted:

- **Separate male clinics:** male only clinic can inform men about all family planning methods and provide condoms and vasectomy. Separate male clinic have been successful in Asia including Bangladesh (matlab male involvement project) and particularly in latin America, including brazil, Colombia, Guatemala, Honduras, Mexico, and Peru. Some offer a range of reproductive health services including care for sexually transmitted diseases and infertility.
- **Better services for men at existing clinics:** some conventional family planning clinics have hired male staff, offered hours convenient for men, and offered additional reproductive health services for men. In Colombia

Profamilia serves men at its women oriented family planning clinics as well as in clinics for men only.

- **Workplace services:** in India, Kenya, the Philippines, turkey, and elsewhere, employers or trade unions provide family planning services to workers, often as part of broader health services.
- **Community based services:** male community based distributors can provide men with condoms and information about family planning. For example, in 1987 the Katibougou Family Health Project in Mali recruited men from the community who distributed condoms from stocks kept in their homes, just as female depot holder in RSDP program in Bangladesh.
- **Commercial and social marketing:** commercial sales have long been men's chief source of condoms. To make supplies more affordable and to increase promotion, social marketing programmes, which sell contraceptives at subsidized prices through established commercial outlets, operate in more than 20 countries including Bangladesh. Men can buy social marketing condoms along with other goods.

8. Research and Evaluation: research is needed for learning about men's motivational factors, generating alternative delivery channels, testing new models and, thus, contributing to improving compliance and contraceptive use; evaluation is needed to ensure that programmes are well- designed and to document their impact.

9. Advocacy

Advocacy - a process to achieve changes in policies or programs- has become increasingly important as a strategy for improving reproductive health since the ICPD in 1994. Nations gathered in Cairo for the ICPD recognized the role of advocacy in gaining support for reproductive health care. Many donor agencies, such as UNFPA, engage in advocacy activities to gain support for population programs and to mobilize resources both at government and community levels.

Advocacy efforts recognize that, in order to build support for family planning and other reproductive health, a variety of different audiences and approaches must be used. To increase men's participation in reproductive health, advocacy activities can be used to address a variety of legislative, institutional, religious and cultural barriers. At the community level, opinion leaders and religious leaders often have negative perceptions of family planning. At the national level, population policies enacted in recent years often do not specifically address men's participation in reproductive health, which can make it difficult for programs to gain support for activities directed to men. Effective advocacy should:

- Define primary and secondary audiences carefully.
- Set realistic objectives
- Design messages based on research
- Have a clear decision making process
- Establish networks and coalitions among supporters
- Use specific advocacy techniques and tools.

8.4 Conclusion

The major message from the field is that reproductive health programmes can accomplish much simply by paying attention to male involvement. Male involvement initiatives need not detract from women's services or jeopardize women's autonomy. The goal is to forge a new partnership, based on mutual respect and cooperation. Acknowledging men's role in reproduction and sexual behavior is an important and necessary step in moving towards this goal.

It is an appropriate time to reassess family planning programme strategies in Bangladesh. New approaches are needed to influence men to bear greater responsibility for the cost of fertility control, both through greater use of male contraceptive methods and by helping them in obtaining appropriate method. Following the agreement at ICPD, the country programme that accepted the challenge to include men in the reproductive health services shows little progress in this line.

Very limited attempts have been made in Bangladesh to involve men in reproductive health programmes that show a dismal lack of progress. Only tangible improvement is an increasing rhetoric that men's integration in reproductive health programmes is important. We do not have enough information on how to involve men effectively in health and family planning programmes. More research is needed to identify the problems of involving men in reproductive health programmes. The country neither developed a nation-wide information and service programme for men's reproductive health nor seriously tried to meet the information needs of men to improve the reproductive health of their partners. More information is needed about the status of men's reproductive health, behaviour that influences their status and their knowledge of what is required to maintain good reproductive health.

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