Working Paper No. 23

Urban Men and Their Participation in Modern Contraception

An Exploratory Study

Shamim Ara Jahan
Aye Aye Thwin
Cristobal Tunon
Sanjida Nasreen

MCH-FP Extension Project (Urban)
Health and Population Extension Division

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Foreword

I am pleased to release this publication on the assessment of health and demographic profile of the urban population of Bangladesh, as part of the research agenda of the MCH-FP Extension Project (Urban) of ICDDR.B. Over the years, the Centre has acquired unique expertise on urban development matters that ranges from research on reproductive health, child survival and environmental issues to providing technical assistance for capacity building to service delivery organizations working in urban areas.

This work has produced important findings on the health status and conditions of city dwellers, particularly the poor and those living in slums in the entire country. The research has also identified service delivery areas in which improvements need be made to enhance effectiveness. Together, these research findings form the basis in designing interventions to be applied in government and non-government settings.

In order to carry out this innovative work, the Centre has established a partnership effort known as the Urban MCH-FP Initiative, with agencies of the Government of Bangladesh and national non-government organizations, notably Concerned Women for Family Planning, a national NGO with wide experience in the delivery of MCH-FP services.

From the government side, this initiative to improve health in cities has the active support and participation of the Ministry of Local Government, Rural Development and Cooperatives, the Directorates of Health and Family Welfare of the Ministry of Health and Family Welfare and Dhaka City Corporation. The partnership receives financial and technical support from the United States Agency for International Development (USAID).

The overall goal of the partnership is to contribute to the reduction of mortality and fertility in urban areas. In practice, this joint work has already resulted in the development and design of interventions to improve access, coordination and sustainability of quality basic health services to urban dwellers with emphasis on the needs of the poor and those living in slum areas.

The Centre looks forward to continuing this collaboration and to assist in the wider dissemination and application of sustainable service delivery strategies in collaboration with providers in government, the NGOs and the private sector.

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The findings of the study were presented at the ICDDR,B Fifth Annual Scientific Conference (ASCON) in Dhaka on January 13, 1996.

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Summary

The study explores the current situation about the perception of men and their participation in modern contraception in urban areas of Dhaka. Key-informant interviews were conducted with men and women residing in selected wards of four randomly chosen zones in the Dhaka City Corporation area. The respondents were selected from the slum and non-slum areas. The first phase of data collection on perceptions and attitudes toward the use of modern male family planning methods and opinions of both men and women regarding effective service-delivery strategies took place during June-July 1995. Later, a follow-up phase to collect further in-depth information from men on fertility preferences and different aspects of contraceptive use was carried out in October 1995.

Although men and women in Dhaka City seem supportive of male contraceptive use in general, certain factors interplay in preventing men from assuming responsibility to use male methods, even when they approve and support spacing and limiting the family size. Urban men are not fully aware about the use and actions of female contraceptive methods, especially clinical methods. This ultimately prevents them from providing active support to their spouses in accepting, using effectively and continuing the methods. Men reported that condoms were uncomfortable. They also perceived condoms as unreliable and feared losing energy and productivity if condoms are used. The same fear of energy and productivity loss exists regarding vasectomy. Couples in both slum and non-slum areas do not have the opportunity to consider all available methods in selecting a particular contraceptive method due to the lack of sufficient information on all methods. Wives play important roles in communicating family planning information to their husbands, as they, in turn, learn about these from field workers. The informants gave recommendations to use the media for motivation of men and stressed the need for privacy and individual counselling.

The perspectives of key-informants highlight the need to understand urban men and their attitudes, and this may pave the way toward developing motivational strategies. The findings reveal that communication between husbands and wives can play a major role in increasing male participation in family planning. Future efforts to promote fertility regulation need to consider ways to counsel couples together and encourage inter-spousal communication and decision- making. An informed public in urban areas represents a setting conducive toward motivating men to improve achievements of a programme that largely attributes its past and present success to targeting women. The findings of the study justify exploring ways to expand choices for urban couples to achieve reproductive health goals.

1. Introduction

In 1994, the International Conference on Population and Development (ICPD) held in Cairo, Egypt, highlighted the need for an equal responsibility between partners for decisions and actions on fertility and reproductive health. The ICPD Programme of Action advocates that family planning programmes should seek to increase men's participation and sharing of responsibility in the actual practice of family planning. To achieve this objective, it is necessary to explore the role, attitudes and perceptions of men toward fertility regulation.

In Bangladesh, the National Family Planning Programme achieved its present success by largely focusing its education and service-delivery strategies on women (for example, female field workers contacting female clients, and clinics staffed mostly by female providers). The availability of modern male contraception methods, i.e. condoms and vasectomies, since the inception of the national programme implied that both men and women were intended consumers of family planning services. In reality, the emphasis has been more toward promoting modern female methods (Population Reports, 1986). Success stories recount how the level of contraceptive use rose dramatically over the last two decades. The contraceptive prevalence rate for any method increased five-fold since 1975, from 8 percent to 45 percent of currently married women in 1993-1994. The use of modern methods grew even faster. The contraceptive prevalence rate for any modern method increased seven-fold since 1975, from 5 percent to 36 percent of currently married women in 1993-1994, of which the contribution of female method use was 32 percent (BDHS 1993-1994). Obviously, this is the reflection of concerted efforts of the programme. Still, a quarter of all couples using family planning rely on male-oriented methods - condoms, vasectomy, withdrawal, or periodic abstinence, which require full male cooperation. According to the BDHS 1993-1994 data, of these male participatory methods, the use of periodic abstinence (4.8 percent) and withdrawal (2.5 percent) is almost

double than the use of modern male methods - condoms (3.0 percent) and vasectomy (1.1 percent). Therefore, it is important to know men's perception and attitudes toward modern male method use to design effective strategies for their promotion.

In the 1980s, sterilization accounted for a large proportion of the overall contraceptive prevalence. Gradually, trends in contraceptive use shifted more toward modern reversible methods. This was largely due to a significant increase in the use of the oral pills from 1985 to 1993, as well as to the decline in popularity of female and male sterilization (BDHS 1993-1994). During the 1970s, male sterilizations accounted for two-thirds to three quarters of all sterilizations provided. But by 1980 and 1981, the proportion of vasectomies performed had declined to 14 and 10 percent (Ross and Huber 1983). Though the condom use increased gradually since 1975, from 0.7 to 3.0 percent, male sterilization prevalence rates have declined since 1989, from 1.5 to 1.1 percent after a gradual increase in the rate during the earlier period (1975-1989) from 0.5 to 1.5. Female sterilization prevalence rates also exhibit the same trends, with a slight decline since 1989 from 9.0 to 8.1 percent after an earlier rapid rise from 0.6 to 9.0. The difference between male and female sterilization prevalence rates increased rapidly from 0.1 since 1975 to 7 percent in 1993-1994. This may be due to the focus on female-oriented methods. At present, the male sterilization prevalence is still very low in comparison with female sterilization (BDHS 1993-1994).

In the past, the family planning programme did not emphasize involving men in its activities, which may be due to the programme's intention to promote female access to means of fertility control. Also, female methods were relatively easier to introduce in the cultural environment of the country, and thus, women became the "captive audience." However, it is now widely believed that men's active participation in adopting family planning methods and their support for their spouses in accepting, using effectively and

continuing female contraceptive methods are vital to meet the programme targets. In this context, men's participation is considered an immediate priority area for the National Family Planning Programme as stated in its Plan of Action prepared by the National Steering Committee in 1994.

The Bangladesh Demographic and Health Survey 1993-1994 indicates a considerable degree of awareness, and approval of contraception among men, which seem juxtaposed with low use of the modern male methods. Thus, the pathways to effective male participation in modern contraception still remain unknown. The BDHS data (1993-1994) also shows that urban men (96.4 percent) approve of family planning more than rural men (91.4 percent). It is presumed that urban men are more informed, and have better access to services, implying a more receptive attitude toward family planning method use. The present study aims to explore the current situation of men's perception and participation in modern contraception in the urban areas of Dhaka. The findings are expected to be a starting point toward the formulation of appropriate and effective approaches to motivate men and increase modern family planning method use in the urban settings of the country.

2. Review of Pertinent Literature

2.1 Fertility and Family-size Preferences

The review explores first the preferences and attitudes of men (and women) regarding fertility, family-size, and the desire to have male or female children which largely relates to the practice of contraception. The Bangladesh Demographic and Health Survey (BDHS) 1993-1994 data show that the proportion of husbands who do not want any more children are quite similar to that among wives (51 against 48 percent respectively). As with women, younger husbands are more likely to want additional children, while older husbands are inclined to want no more. As the number of children increases,

both husband and wife are likely to want no more children. Generally, the desire to have no more children among married couples increases with the birth of each additional child. The BDHS results indicate a distinct difference between couples with one child and couples with two or more children wanting to have no more children (5.6 percent versus 41.1 percent).

Most researchers conclude that, in Bangladesh, sex preference is an important factor in determining family size. Aziz and Maloney (1985) indicated that desire for male children stems from economic and familial reasons. Parents tend to project their own hopes and aspirations on their sons in particular, and try to fulfil those hopes through education and bequeathing property and position. Female babies are welcomed for the psychological satisfaction they are expected to give. Mazumder (1993) found that men's main reasons for desiring a son are economic, in terms of old age security and income earning potential. Family continuity was another important reason to desire a son. Donahoe (1995) highlighted that there is not much information about the value of children to men, including their attitudes towards sons versus daughters. Her paper questioned whether the resolve of men to want small families would weaken, should the first two children be girls. On the other hand, what are the family size preferences of urban men? What are their attitudes toward sons and daughters? Do factors, such as crowding and scarce resources for basic needs in slums, make the male earner to desire fewer children? The present study attempts to formulate some initial responses to these questions.

2.2 Contraceptive Awareness Toward Modern Male Method Use

The BDHS 1993-1994 data show that of 36.2 percent modern method users among currently married women, condom and vasectomy user rates are only 3.0 and 1.1 percent, respectively. The modern male method use (4.2 percent) is considerably low in contrast to the female method use (32.1

percent). The BDHS data further indicate that, in urban areas, 44.6 percent of the currently married women use modern contraception compared to the 35.1 percent in the rural areas. There is a sharp difference in condom use between urban (8 percent) and rural (2 percent) couples. The data clearly indicate that the active participation of men in modern family planning method use is low, but there is a higher prevalence among urban men compared to that of rural men.

The condom is an effective method if used correctly and has very little side-effects. The qualitative work on condom use in Bangladesh by Folmar et al. (1992) revealed that most condom users were satisfied with condoms as a method of birth control. Furthermore, only 52.4 percent of condom users indicated that their level of sexual satisfaction remained about the same as when they do not use condoms. Thirty-seven percent reported that sexual pleasure decreased, while 10.6 percent thought condom use enhanced satisfaction.

The other modern male method, vasectomy - a permanent family planning method - is almost completely effective, and recent improvements are simplifying the clinical procedures further. It is a suitable birth control method for those couples who have completed their preferred family-size and want no more children. The key events leading to a couple's decision for male or female sterilization include the decision to have no more children and the decision to switch from temporary family planning methods to a permanent method of contraception (Faisel et al., 1995). Although female sterilization is the second most popular contraceptive method in Bangladesh, male sterilization is least used, i.e. by only 1.1 percent of married couples, despite the fact that vasectomies are quicker, cheaper, safer, and involve fewer complications than tubectomies. Islam and Rahman (1993) revealed that about 94 percent of the vasectomy users reported that it was a correct decision, and 90 percent of them were satisfied with the outcome. The

dominant reason for satisfaction was that they would not have any more children. When vasectomy users were asked about the status of their conjugal relationship, 83 percent reported that there was no change and 14 percent mentioned that it had improved. Regarding sexual ability, 82.4 percent reported that it had remained unchanged and 14.4 percent reported improvements (Islam and Rahman, 1993). The findings of a qualitative study on "Vasectomy Decision-Making in Bangladesh" by Faisel et al. (1995) showed that vasectomy users were very clearly convinced of the many advantages of the operation and the reasons for choosing vasectomy mentioned by them were permanency, dissatisfaction with other methods, safety and being risk-free.

The BDHS 1993-1994 data show that 95 percent of husbands of currently married women know about condoms and 89 percent are aware of male sterilization. Much of this knowledge appeared to be superficial as the use of modern male methods is actually quite low. Thus, knowing only the name of the family planning methods is of little consequence unless men actually know how to use the method or what possible side-effects are related to its use. Folmar et al. (1992) found that condom users were not fully informed on the proper techniques of using condoms. The present study tries to assess the knowledge of urban men concerning the use of modern family planning methods. The study also explores whether the lack of detailed knowledge on modern male methods act as a barrier toward selecting a male method.

2.3 Attitudes Toward Contraceptive Use

Men's attitudes toward family planning and contraceptive methods were further explored in the available literature to identify barriers against their active practice of contraception. Gallen (1986) reported that different surveys of men's attitudes toward family planning, conducted in the early 1980s in

India, other Caribbean countries, Latin America and the US, suggested that many men favour family planning. In these surveys, 65 to over 90 percent of men expressed approval of family planning. The findings of the analysis of data from 17 DHS surveys, conducted over a seven-year period (1987-93) in 15 African and Asia countries indicated that West African men were less positive toward the use of contraceptives than in any other region (Ezeh et al., 1996). In Cameroon, Mali, and Senegal, over half the men oppose the idea of family planning. Ghana was the only country in West Africa where at least three-quarters of men approve of family planning. In East Africa, over 90 percent of the men approve of contraception with the exception of Tanzania, where approval rates among men reach only about 78 percent. Men's approval of family planning was also high in North Africa and Asia, except for Pakistan, where only 72 percent of the men were positive about contraception. The situation in Bangladesh seems much more favourable, as 92 percent of the husbands reported that they approve of family planning (BDHS, 1993-1994).

In Africa - once considered the stronghold of opposition to male contraceptive use - recent suveys on men's attitudes toward family planning found that a substantial majority of men approved of family planning (Population Reports, 1986). Mustafa and Mumford (1982) conducted a survey of men in Sudan, the findings of which showed strong positive attitudes toward family planning. Three-fifths of the respondents whose wives were of child-bearing age said that they wished to use family planning services, although few were actually using a method. Ginn et al. (1989) painted a generally positive picture of male attitudes toward family planning in Burkina Faso. According to Oni and Carthy (1991), in Nigeria, men's attitudes toward contraceptive use is quite favourable, although there is a considerable variation by socio-economic status. They added that men were somewhat more willing to support their wives in using contraceptives than they were willing to consider using it themselves. Ezeh (1993) conducted a study in

Ghana to explore the influence of spouses over each other's contraceptive attitudes. The results of the study showed that a woman's contraceptive attitude depended not only on her individual characteristics, but also on the characteristics of her husband. On the other hand, the study findings revealed that the woman's characteristics actually do not affect her husband's family planning attitudes.

Few surveys on men's attitudes toward family planning have been conducted in Bangladesh. Bernhart and Uddin (1990) conducted a study with husbands who were identified by their wives as religiously opposed to family planning. Unexpectedly, 26 percent of the "opposing" husbands reported that they were current users of a contraceptive (their wives had reported no use) and an additional 50 percent, although not practising, said that they were in favour of family planning. Of the alleged "opposers", only 23 percent opposed family planning on religious grounds. One-fourth of this group was able to cite specific Islamic injunctions against family planning. The vast majority of these men could give only vague reasons why their religion forbids family planning (Bernhart and Uddin, 1990). Mazumder (1993) also found in Chandpur district that religious opposition was generally not based on specific knowledge of the tenets of Islam. There was a slight difference in religious opposition between urban and rural areas (Mazumder, 1993). Davies et al. (1987), in a study undertaken for the Bangladesh Social Marketing Project, indicated that, in addition to collecting the pill supplies for their wives, Bangladeshi men also play an important role in helping them understand how to use the method.

In truth, a study on men's attitudes toward family planning and contraceptive use will not be enough to understand their attitudes toward the use of male methods. Most study showed that men are positive toward fertility regulation and contraceptive use, still there is a need to find out their attitudes toward male contraceptive use. In this particular area not much

work has been done. This provides a basis for exploring further the attitudes of men toward male contraceptive use especifically in the urban areas of Bangladesh as a focus in the present study.

2.4 Communication and Motivational Strategies

Aziz and Maloney (1985) recommended a motivational programme for male participation to reduce fertility levels. Folmar et al. (1992) suggested that the distribution of condoms may be enhanced if information and advertising can be aimed at reducing the embarrassment associated with condoms. In addition, education materials should emphasize the proper techniques of using condoms. Salway et al. (1993) documented the opinions and perceptions of family planning field workers regarding male involvement in family planning. For increasing active participation of men in family planning the female field workers suggested to use the male field workers, mass media and male local leaders for motivation. Faisel et al. (1995) recommended that service providers should be encouraged to give information on vasectomy to all men that they come in contact with. They also recommended that the advantages of vasectomy should be stressed through radio spots, in promotional materials, and in counselling.

Based on a thorough review of the literature on men and family planning in Bangladesh, Donahoe (1995) specified that the absence of adequate research findings on how men form opinions about family-size, how they decide to use contraception, how inter-spousal communication for decision-making takes place and also how men come to use or reject male contraceptive methods makes it difficult to design the effective programme strategies aimed at men. Before incorporating any new strategies into the National Family Planning Programme, it is important to understand the perceptions and attitudes of men toward family planning, measure their demand, and seek suggestions for future action. Therefore, the present study

also attempts to document the opinions of urban men regarding effective service-delivery strategies.

3. Objectives of the Study

The present study was conducted:

1. to assess fertility and family-size preferences among urban men
2. to examine modern contraceptive awareness among urban men
3. to understand the attitudes of urban men and women toward modern contraceptive use
4. to report opinions of urban men and women regarding effective service-delivery strategies.

4. Design and Methodology

4.1.a Stage I

An overview of urban men's participation in family planning was obtained through a rapid appraisal, with a purposive sample of "slum" and "non-slum" areas within the old, new and intermediate sections of Dhaka City through a multi-stage sampling procedure. The sample included four zones of Dhaka City Corporation (DCC) which were selected randomly, with further random sampling of two wards from each zone. Following the slum list from the 1991 Dhaka Metropolitan slum survey, with an updated list of new wards and ward maps, one slum area from each selected ward was selected by simple random sampling. Then, a selection process was applied to choose non-slum areas located at a five-minute rickshaw ride distance from each selected slum.

The informants were community members (both men and women) residing in the slum and non-slum areas of Zone 2, 4, 6, and 8 in DCC.

Thirty-two key-informant interviews (16 men and 16 women) were held in the first phase to collect information on perceptions and attitudes toward modern male family planning method use and opinions regarding effective service-delivery strategies. During the interview, both male and female respondents acted as key-informants of the situation in the community and also relayed their own experiences. The first phase of data collection took place during June-July 1995.

4.1.b Stage II

This stage involved reinterviewing the male key informants of the first stage for further in-depth information on different aspects of contraceptive use in October 1995. Sixteen interviews specifically with men were held to collect information on issues related to male family planning method use. A pretested interview guideline was used, and all interviews were conducted by experienced professional research staff members of the MCH-FP Extension Project (Urban). Male informants were interviewed separately by male interviewers during Fridays and after work hours on weekdays. The guideline contained mostly unstructured, open-ended questions that permit informants to lead the interviews, and discuss freely on opinions and choices with interviewers facilitating and probing for clarification of problems, attitudes, and rationale. The interview guideline focussed on fertility and family-size preferences, awareness of modern contraceptive use, knowledge and experiences with contraceptive methods and discussion and decision to use specific methods. During the interview, the male informants provided information of the situation prevalent in the community and also discussed issues based on their own experiences.

The interviews took place mostly during the day, except for the interviews with the male informants which had to be done on Fridays, Saturdays, and in the evening. The interviewers used tape recorders and,

sometimes, were assisted by note takers to record the maximum information generated. The interviewers listened to the tapes and transcribed the recorded information, which was in Bangla. The hand-written notes were edited and then translated into English.

Analysis of data was done according to individual informant groups. Repeated reviews of the transcripts provided themes and patterns for each of the topic areas.

4.1.c Sample Description of Key-informants

The urban men interviewed came from a wide range of occupational backgrounds. The slum male informants represent rickshaw mechanics and pullers and a few who own rickshaws operated by others. Other slum men in the sample were a baby taxi driver, a teashop owner, and one man who has a plant nursery. The non-slum men in the sample were mostly businessmen, store owners or government service personnel. They were better educated, at secondary school levels and higher, whereas the slum male informants did not attain beyond the primary school level. The household income of the slum male informants ranged from Tk. 1300 to Tk. 3500. A wider variation was noted in the non-slum sample, namely between Tk. 2500 and 9000.

Slum men in the sample had smaller families, five persons on average, with a range from 3 to 9 persons. The families of non-slum men in the sample are larger, seven members on an average, varying from 3 to 13 persons. The average duration of marriage among men in the sample from both the slum and non-slum areas was eight years. There was a higher use of contraception, mostly condoms, among the non-slum male informants in comparison with those from the slums.

The average male informant in the sample was 33 years old, and the average female was 25 years. The slum men and women interviewed have been living in the present neighbourhood for 13 years, the non-slum men for 16 years and the women for four years, which provides a basis to function as key-informants for the area.

5. Results

5.1 Part I: Male Perspectives on Family Planning

This section presents the views of urban men in both the slum and non-slum areas. The informants' preferences on family-size, their sources of information on contraception, and their knowledge and experiences with specific methods are shown below.

5.1.1 Fertility and Family-size Preferences among Urban Men

The majority of men in both the slum and non-slum areas with only one child wanted to have another. Some of them wanted to delay the next birth as their younger children were too small. When they were asked about their preferences for the next child, those who have daughters expressed their desire to have a son. On the other hand, those who already had a son did not specify any additional preferences. Men with two or more children having at least one son did not desire any more children, whereas those with children having no son wanted to have more.

The process through which men, women and/or couples make decisions about family-size was examined through an inquiry of whether men discuss desired family-size with their wives. Interspousal interaction for the slum and non-slum men is quite similar. Most men in both the slum and non-slum areas discussed their desire for having more children or otherwise with their wives. There were some who did not do so, and did not think that it was an issue.

Issues that needed to be considered in having a child were further outlined. Most men from both the slum and non-slum areas considered the economic situation of the family before having another child particularly their ability to provide them with sufficient food, education, and clothing. Men also thought that the distribution of assets, property, as well as living space were important issues to be taken into account. Male informants in both the slum and non-slum areas asserted that men considered the health of the mother as a factor since mothers need to be stronger to bear children. Some informants in the non-slum areas also reported that the age of parents was a deciding factor to have more children. Some men felt that a smaller number of children would be easier for the parents to manage and care properly.

Key-informants reported on what men consider as future benefits of having children. Men felt that children will ensure security and mental peace in the old age. Most men believed that they should have children to maintain heritage, lineage, or clanship. Having children is fulfilling when one is able to provide and distribute one's property or material assets later in life, which is also related with having a son. Thus, a son in the family was valued strongly as being able to maintain and distribute benefits.

Both the slum and non-slum men considered that two children would be the ideal number for a family. They were further asked whether this consideration was related with any gender preferences. Some men preferred to have one son and one daughter, others could not specify their preferences. A few respondents preferred three children as an ideal family and emphasized on having at least one son. The most common reason given for having more children than the preferred number was the desire to have a boy or girl among those who had children of the same sex.

Men also stated that the improper use of family planning methods especially oral pills by their wives resulted in having more children than desired. One slum man said,

> *'My wife used to take oral pills before my last child. She forgot to take her pills regularly. So, she conceived accidentally due to her mistake in taking pills. It was not my fault. Subsequently, I thought of washing the pregnancy (MR). Then I felt that, conception has already taken place, and there is no use of washing it. It is my baby after all, nothing else. In this way, we accepted yet another child with the promise that we would not make this sort of mistake again.'*

The main reason for wanting a son was to maintain lineage, and the son would be regarded as the old age security to the parents. Men also mentioned that sons would stay with parents, earn for the family, take care of them, and be responsible to arrange for their burial at the end. Men felt that daughters provide emotional support to their mothers, and would help in household activities. The benefits that men gain from daughters included acquiring a son-in-law, and that daughters would provide care and respect them more than sons would.

5.1.2 Modern Contraceptive Awareness among Urban Men

5.1.2.a Discussion and Decision to Use Family Planning Methods

Decisions regarding the use of family planning methods commonly took place in two different ways. It was either a joint decision, where husband and wife both discussed a specific method, decided together to adopt that method, and then started using the method, or it could also be entirely the individual decision of one of the partners. In the case of the latter, either husband or

wife selected a method according to his or her choice, took the decision independently, and later informed the spouse.

Key-informants reported that the non-slum husbands and wives jointly decided to use a method, whereas most slum women decided to use a method and then informed their husbands later. Slum men reluctantly reported that their wives discussed with the field workers or neighbours about the methods (mostly pills and injectables) and took the decision by themselves. Two slum men decided by themselves about the use of female methods, namely, pill and ligation, and then convinced their wives to take up the methods.

There was discussion on whether all available methods were considered before deciding to start practicing family planning. The purpose was to understand the process through which men and women separately, or as couples make decisions about using specific family planning methods. Those couples who took joint decisions discussed a few, but not all methods among themselves. Most couples did not have sufficient information about all the methods and, therefore, were not able to discuss the methods in full range. Some men felt that they did not get enough scope for discussion about the methods as their wives were already convinced about a specific method and had already decided to go ahead and used it. One man whose wife was ligated said,

> *After delivering the last child in the clinic, the doctor of that clinic suggested that we undergo ligation, and I took decision on the spot and convinced my wife. So there was no time to discuss about all other methods.'*

5.1.2.b Source of Information on Family Planning Methods

Most commonly urban men first heard about family planning methods from their wives, neighbours, radio and TV. Other sources included government hospitals, family planning clinics, friends, and relatives. Men felt that the field workers were a source of information and method supply mostly for female methods. Women learned about contraceptive methods from field workers and shared the information with their husbands.

Non-clinical contraceptives were obtained from pharmacies and field workers and clinical methods from NGO clinics and government hospitals. Generally, urban consumers were quite satisfied with NGO family planning services because of good behaviour, check-ups by the clinic staff, doorstep supply of contraceptives and follow-up by the field workers. Pharmacies were preferred for the easy availability of contraceptives within close distances. Field workers were appreciated for coming regularly to the house, and some disliked the notion of having home visits reduced. Users of permanent methods were less satisfied with services at the Dhaka Medical College Hospital due to crowding and the lack of medical supplies.

5.1.2.c Reasons for Choosing Specific Methods

This section concerns men's perspectives regarding the choice of certain methods. The informants were those whose wives were currently using contraceptives. Most men and/or their spouses used family planning methods to space births and limit family size. Reasons for choosing the specific method among all others varied quite a bit. Men felt that pills were chosen out of fear from using clinical methods. Other reasons why pills were chosen included a cheaper price, being easily available and distributed at the doorstep by the field workers. Some men had the impression that the oral pill was a good choice, as it produced good health and weight gain. Injectables and IUDs were chosen for the convenience due to a longer time interval between each application.

5.1.2.d Knowledge on Specific Methods

Men from both the slum and non-slum areas were conversant mostly about non-clinical methods, especially oral contraceptives. They indicated that oral pills should be taken daily at night. Some slum men added that if a woman forgets to take the pill for one day, she needs to take two pills together the next day. The majority of urban men understood that the common side-effects from oral pill use were headache and nausea. Other side-effects specified were irregular menstruation, stomach pain, weakness, weight gain, chest pain, and reduction of breast-milk.

Most men could not specify the appropriate timing for IUD and injectable use nor even the duration of effectiveness of these methods. The majority were unaware of specific details regarding these methods, implying that these were obtained from clinics by women themselves. A few non-slum men mentioned that injectables need to be pushed in one's hip at a 3-month interval. The side-effects from injectable use were irregular menstruation and heavy bleeding.

One slum man said that IUD was inserted by doctors, and that the procedure involved no pain. Men perceived that there are no side-effects with IUD use and with tubal ligation. One non-slum man made an interesting point about IUD use:

> *'The cord where the child forms was patched up to prevent pregnancy.'*

Most men in the urban areas knew that ligation is a permanent method. One added that it is a minor operation.

5.1.2.e Experience with Method Use

Most men whose wives were currently using contraceptives did not express that they were facing any problems with the method used. However, a few shared their own bad experiences with some methods. Slum men reported that headache, weakness, dizziness and chest pain occur as side-effects due to pill use. They also indicated that excessive bleeding, back pain and pain in lower abdomen can be acquired from injectable use. Most men learned about side-effects from contraceptives, when their wives discussed the problems with them. One slum man shared a bad experience with pill use,

> *'After taking "Maya Bori" my wife had suffered from headache, weakness, and dizziness. I had been to the Nari Moitree clinic to discuss this problem. I talked to the doctor and also to the field workers who come to this area. The doctor said that we could continue taking pills or switch over to injectables. Then my wife said that she would prefer injectables because she could not always remember to take pills. So, we decided that injectables would be suitable for her as it needs to be administered only every three months. My wife has not yet started taking injectable.'*

One non-slum man shared his experiences with injectable use,

> *'Due to injectable use, my wife had severe bleeding, which she did not have even during delivery. At first, we went to the outdoor (OPD) of the Dhaka Medical College Hospital. They advised us to talk to the field worker. Then we went to the government family planning clinic. They said, "this is not our patient". Then we went to an 'Apa' (lady doctor) of the Gynae department. She prescribed 'Metaljin' tablets. After 2-3 days of taking these, the bleeding reduced. We went to that 'Apa' again who gave us some more medicine and thus, she was cured. We*

still want to have children later and thus we shall choose a temporary method after talking to a doctor'.

Women discussed their problems of method use with their husbands, and side-effects can cause couples to discontinue methods. On the other hand, men whose wives were using contraceptives without any problems would prefer to continue these methods. When asked whether they would consider switching to permanent methods in the future, most men showed unwillingness to do so.

5.1.2.f Attitudes Toward and Experiences with Modern Male Methods

The majority of current condom users in the non-slum areas started using the method after their wives had bad experiences with pill, injectable and IUD use. Men reported that condoms were preferred as there are no side-effects like female methods. They added that it is necessary to use condoms only at the time of intercourse.

One man in the non-slum areas said that he had no alternative for contraception except to use the condom after the negative experience with pills and injectable use suffered by his wife.

Men obtained condoms mostly from pharmacies, sometimes their wives collected them from the field workers during home visits. Most male informants discussed freely with the interviewers about how to apply condoms. Their experiences with condom use provided information on the proper use of condoms. The non-slum men reported that the instructions inside the condom packets were useful to learn about proper condom use. The following reports from the non-slum men are illustrative:

'I faced problems with condoms initially when air entered inside the condom during use, and also when it kept slipping off during intercourse. But since the last six months, one cartoon demonstrating techniques on how to use the condom, is added with the condom packet and from that I have learnt and practised. Now I can handle that well.'

'I have learnt how to use condoms in detail from the newspaper, from an article in the editorial column about condoms. That article helped me a lot.'

Some of the slum and non-slum men have used condoms. These men shared freely the problems faced during condom use, which ultimately became reasons for rejecting this method. From their past experiences, most men reported that condoms burst and sometimes leaked and, thus, were not reliable. Other problems included difficulty in application, a decrease in sexual enjoyment, a lack of comfort, slipping off during intercourse, allergic reactions in the woman's vagina and sometimes a burning sensation at the male sexual organ. Lack of privacy in crowded urban households also produced indirect problems, such as difficulty in storing condoms and discarding after use. Another problem was the embarrassment in purchasing condoms. Many discussed these problems with their friends who also shared similar problems. Due to these problems, they stopped using condoms, and their wives started using female methods. Two examples from the non-slum dwellers are typical:

'I used condoms after the birth of my first child. There was a hole in one of the condoms and my wife became pregnant. We did not want the second child so soon as the first child was only 9 months old. So, the pregnancy was terminated with MR after two months of conceiving and after that, she started using pills.'

'I did not face any problems with condom use. But purchasing condoms becomes difficult. I am afraid to let people see me buying condoms. If there are other people in the shop, I do not buy. I have told the shopkeeper to keep condoms for me in a different packet. So, whenever I go, I bring the packet.'

One slum man said that condom use caused "*dhojobhanga*" (premature ejaculation). Another slum man said that "*condom dekleye ghanna laage, sex chole jai*" (the sight of a condom makes sexual desire disappear). They heard of problems (such as the ones mentioned above) from their friends, relatives and neighbours and strongly believed that such information is valid. The majority of slum men never used condoms.

Most men in both the slum and non-slum areas showed negative attitudes toward vasectomy use because of its permanency. The few slum and non-slum men who preferred to undergo vasectomy stated that they would do so only after having 3-5 children. One slum man said that it is a method required only for the older men.

5.2 Part Ii: Perspectives on Male Involvement in Family Planning

This section concerns the views from both urban men and women in the slum and non-slum areas of Dhaka City regarding modern contraceptive use and male methods for family planning. Opinions and ideas were also provided regarding effective service-delivery strategies aimed at increasing male participation in family planning.

5.2.1 Attitudes of Urban Men and Women Toward Modern Male Methods of Contraception

Most men were positive toward the use of male methods for family planning. A frequent reason - given by men - for supporting greater male involvement in family planning was that men have the responsibility to decide on the family-size limit. Men felt that they would use family planning methods properly as women often forget to take pills correctly. Another common reason given by men from the non-slum areas was the desire to save their spouses from side-effects associated with the use of female methods for family planning

> *'Women sometimes face problems after taking pills. I do not allow my wife to take pills because it causes less production of breast-milk. I have heard other women complain of headache and weight gain. Men do not face any problems for method use. Therefore, they should rather use condom.'*

> *'Men encourage their wives to use family planning methods that usually give numerous side-effects. They should also try to understand their wives' problems.'*

Women considered that having side-effects from hormonal contraceptives is a good reason for men to use a male method of contraception. Women with problems and bad experiences from side-effects due to method use strongly felt that men should understand these aspects and should, therefore, use male methods.

> *'Due to pill use I feel weak and dizzy, and have become thin. I am his wife, yet my husband has no feelings for me.'*

`I cannot take pills and also injectables as these methods do not suit me. After I took the injectable, there was severe bleeding for four months, and I became very weak, after which I stopped taking injectable. I think that my husband should use family planning methods.'

Some women asserted that working women should not use contraceptives as they are physically burdened with both work and child care. They perceived that husbands can share the responsibility of contraceptive use as these women are working hard. Women felt that using contraceptives causes them to become unhealthy and unattractive by gaining weight and/or having bad complexion, which, in turn, cause their husbands to remarry.

`Nowadays women have to look after children, and they have to work outside the home. Furthermore, they have to work at home when they come back from work. When their complexion becomes shabby, their husbands marry another women. It would be better for men to use contraceptives and experience the hazard of contraceptive use.'

`The health of poor working women breaks down from a combination of insufficient food, hard work, and the side-effects of contraceptives. There is a growing dislike and intolerance for these among men, and many of them marry again.'

Some women in the non-slum areas felt that men should use condoms as protection against AIDS, and to help in certain cases where women have health problems (such as those with heart and kidney diseases). Some women felt that men should use condoms to prevent extra-marital/illegitimate and "unauthorized" pregnancies. (If a woman becomes pregnant by a man other than her husband, apparently, that pregnancy is assumed to be unacceptable

by society and is termed as "unauthorized".) Women felt that men who are sexually active with more than one partner are usually responsible for this kind of pregnancy and that such male sexual behaviour is not acceptable to their wives. One slum woman said,

> *'Men go to many places, and there may be an accidental, unauthorized pregnancy. The women who conceive in this way have to go through all kinds of miseries, but the men who are also responsible for this feel nothing. This child will cause more problems to society.'*

Some slum men supported this view. They reported that it is possible for a man who is sexually active with more than one partner to produce more births than a woman within a certain period.

> *'If a woman wants a child then she has to wait one year. But a man can make five women pregnant in one day. So men should adopt protective measures.'*

The issue raised was that men having sexual relations with several women are more likely than women to have procreated more children by the end of their reproductive lives.

There were also mixed views considering the available choices of male contraceptive methods. Although men agreed that more male participation in method use is necessary, they desired a wider range of methods other than condoms and vasectomy. The fact that there are more female methods available enable those men (and women) against male participation to reject male method use. One non-slum woman said that men have to work hard, and therefore, it is better that they avoid side-effects and let women to use contraceptives as they stay at home.

Perceptions and misconceptions relating to modern male methods use were discussed at length. Those against male method use stated that condom use is unreliable, uncomfortable, and troublesome. Some urban dwellers felt that using condoms necessitates that men should have good food to remain healthy, and thus, is more suitable for the rich people. Some felt that vasectomy causes men to lose their strength, make them unable to work hard, hampers the sexual enjoyment, and may also cause death. Men feared permanency of the method, referring to the rumor that it is similar to castration. They also believed that they cannot perform sexually after the procedure. One slum man said,

> *'If a man takes a permanent method, i.e. vasectomy, he will not be a "complete man" anymore. He won't be able to claim that he's a man after the operation.'*

One non-slum man said,

> *'A vasectomized man is criticized by others when he goes outside, but a ligated woman does not hear the criticism as she is not going outside.'*

5.2.2 Opinions of Urban Men and Women Regarding Effective Service-delivery Strategies

Men in Dhaka City were able to share their views and opinions openly, regarding effective service-delivery strategies. Most suggested that male counsellors need to seek men and make them understand about the benefits of family planning and provide information about family planning methods to motivate them to use contraceptive methods. The need for male counsellors was also raised by women as they felt that a man-to-man approach is more appropriate.

Some men proposed that respective ward commissioners and local leaders could organize group meetings to provide information on family planning methods. They also mentioned gathering events for men to talk about contraceptive methods where users could share their experiences with specific methods. Men strongly felt that, as mass media, like radio and television, are easily accessible in the urban areas, these media could play an important role for motivating men to adopt male methods, such as through advertisements. *One slum woman insisted that the government should enact a law that requires men to use family planning methods.*

The slum men expressed the need for interspousal communication, in that women can motivate their husbands to use family planning methods. This was strongly supported by a large number of women in both the slum and non-slum areas. At this point, women indicated that they knew of different methods from the field workers, and therefore, should communicate this information to their husbands and motivate them to use male methods.

> *'Women understand best about the personal affairs of their husbands, and therefore, can motivate and request their husbands to use family planning methods.'*

> *'It is time for women to tell their husbands about their problems with family planning methods use. They have to convince their husbands.'*

A few men felt that men could be motivated by their neighbours or their relatives. Neighbours or relatives using family planning methods could share their experiences, so that more men would be convinced about the methods and ultimately male method use will be increased. Mostly men voiced the need to discover "more male methods" in the form of injectables or pills to increase more male method use.

6. Discussion of Key Findings

The findings from this preliminary study on the views of urban men and women on modern male contraception have important implications for promoting men participation in family planning. The perspectives of key-informants provided a glimpse into the preferences and attitudes of men in the urban areas toward fertility and male contraceptive method use. The specific issues are outlined as follows:

Fertility and Family-size Preferences

The findings revealed that men did not want large families, and two children were considered the ideal number of children. Urban men prefered having at least one son and the reasons mentioned were mainly psychological, economic (concerning inheritance, family continuity, old-age security, such as assurance for their burial), and cultural (that in Bangladesh, sons normally take care of parents). Son preference seem to be a common factor for having more children than the preferred ideal number of two children. In the urban areas, sex preference plays a major role in creating large families, even when men would normally prefer to raise and support small families.

Modern Contraceptive Awareness

The findings revealed that in the non-slum areas decisions regarding family planning method use were taken jointly both by husbands and wives. The decision was taken after discussing a few specific methods, but not all available methods. This was due to the lack of information of what is available to whom, and where it may be obtained. In the slum areas, the decision was taken mostly by the wives, which was later supported by their husbands. The communal setting of the slums enable the field workers as well as the neighbours to have a considerable influence on the slum women, who themselves are relatively more autonomous in taking decisions for specific needs unlike the non-slum women.

In both the slum and non-slum areas, some available methods were not considered during the selection of a particular method due to the lack of enough information. Well-informed men can talk with their wives and cooperate in assessing their needs to choose a family planning method. However, men usually lack access toward family planning information services and, therefore, often are at peril to rumours and misconceptions prevailing in the community.

The findings also support the notion that wives play important roles in communicating family planning information to their husbands. Urban men heared about family planning methods, especially female methods from their wives who, in turn, learned about these from the field workers. Often at times, targeting women through doorstep delivery of contraceptives may have been the only channel to have facilitated men's knowledge of family planning.

The findings of the study support that urban men are not fully aware about the use and actions of specific family planning methods, especially female methods. They do not clearly understand the basic aspects of injectables and IUDs, how these contraceptives should be used and what their side-effects are. Urban men know very little about the side-effects of female methods, especially clinical methods. This prevents men from providing active support to their spouses in continuing clinical methods. They have misconceptions regarding modern male methods and are misinformed about female methods. Being well-informed enables men to use methods themselves or support their partners in using a method.

Regarding the actual male method use, the study identifies variations among the male method users. Negative experiences with condoms dissuaded the condom users from further use, and rumours prevent never-users from using the condom, even when both of these groups approve and support spacing, and want to limit family size. Even so, there were some condom

users who were satisfied with the method and showed interest in continuing the method. This group strongly believed that the knowledge of proper condom use and its practice were important in continuing condom use. Most urban men in both the slum and non-slum areas seemed least interested in vasectomies. They were not well informed about this method, and had different misconceptions regarding its use. Men's lack of initiatives to use modern male methods is probably due to the lack of information, as well as their belief in unfounded rumours, such as the rumour that vasectomy reduces sexual power and enjoyment, or that the condom is unreliable, and it bursts and leaks. If a person does not know of a method, or has heard of it, but does not have enough information to use it, that method is not an option (Ringheim, 1993). This points to an unmet need for information services for urban men.

Attitudes Toward Modern Contraceptive Use

Both the urban men and women favour increasing male participation in modern family planning method use. The non-slum men are more aware than the slum men about the side-effects with female family planning methods, and this awareness has become a common reason to use male methods.

The study documents the remarkable gap between the attitudes of urban men toward modern male family planning methods use and the actual responsibility in using modern male methods. Men who wanted no more children, or to delay the next child, indicated their acceptance of family planning, but only a few were actually using a male method. Different misconceptions and popular rumours about the existing male methods were responsible for this gap and should be explored further. Ringheim (1993) said that the discrepancy between belief and action in using male methods might be due, partly, to limited contraceptive choices that men have.

Opinions Regarding Effective Service-delivery Strategies

In the study, urban men and women shared their valuable opinions regarding effective service-delivery strategies. They desired individual counselling by the male workers, probably stemming from the need to privacy, and to be able to discuss freely and inquired about fears and misconceptions relating to modern male method use.

The role of the mass media and group meetings for providing important messages on different family planning methods was emphasized by both the male and female informants. The demand for new male methods indicate that the lack of detailed knowledge on the available male family planning methods causes men to raise this issue. However, Ringheim (1993) mentioned that the introduction of new male methods might increase male involvement and contraceptive use. She also added that a reversible, non-coitus-dependent method might substantially alter the willingness of men to take the responsibility for fertility regulation.

7. Research Needs

The findings from this exploratory study suggest further research to increase our understanding of important determinants of urban male involvement in modern contraception. In the first place, there are widely held beliefs about modern male contraception that seem to be important factors inhibiting the use of condoms and vasectomies among both the slum and non-slum men. It is important to continue to look into these factors. More studies are needed on the perceptions of current users and ever-users of modern contraception to devise strategies to reach men with accurate information through credible sources, including both community groups and the media. In this respect, more information is also required on how to improve communication to men through producers and providers of contraceptive commodities.

At the same time, male erroneous perceptions about modern male contraception should not be dismissed as just unfounded misconceptions. Rumours and beliefs about the unreliability of condoms and the dangers of vasectomies are so widespread as to call for research to ensure the effective monitoring of quality in logistics management and clinical procedures related to these methods.

Above all, it is important to conduct more in-depth, qualitative studies that would provide insights into males' attitudes toward family life and son preferences, particularly among the slum dwellers. Such research can produce findings to help design more comprehensive communication strategies that will address not only knowledge about contraceptive commodities and services, but that will also provide a wider perspective on the role of modern men and women in society that is congruent with the use of modern male contraceptive methods.

8. Conclusions and Policy Implications

Even when urban men adhere to a small family norm, preferences for male children seem to affect their contraceptive practices. Many factors, linked to the traditional role of men and women in the household, influence this behaviour. Education on family life, providing new alternative role model for men, should be incorporated in the programme. The mass media, like Radio and TV, can be used for such programme using the famous people as the new role models. Education on sex determination, value of girl child and human rights need to be emphasized in the programme. At the community level, local groups can be provided orientation on reproductive health, and the service providers should work with them. The clinic services should be made more accessible for men by changing the clinic hours. Well-men clinics with male counsellor can be started.

It seems that the non-slum men are more likely to take decisions jointly with their wives in using specific family planning methods. Slum men seem to assume a role supporting the choices made by their wives. Before selecting a specific method, the discussion on contraceptives among couples does not cover the full range of available choices. The lack of information on family planning methods prevents a comprehensive discussion for couples that could have enabled them to make appropriate choices from the entire range of services available to them. Programmatically it is very much required that men will assume the equal responsibility for reproductive health issues and couples make decisions jointly. It requires informing couples of a full range of methods and the sources of care. Special types of service providers would be essential for the task, to be empowered with skills to counsel and advise couples together. In a sense, experienced female family planning personnel could also be suitable, should they be "empowered" with sufficient skills and capacity for such actions.

From the perspectives of both men and women, it is clear that communication between husbands and wives can play a major role in increasing men's participation in family planning. Future efforts to promote fertility regulation need to consider ways to counsel couples together and encourage inter-spousal communication and decision-making. The mass media, like radio and TV, can be used in promoting interspousal communication. This can be highlighted in population education programme.

Urban men are misinformed about female contraceptive methods, especially clinical methods, and do not have enough basic information about the different methods, which ultimately prevents them from providing active support to their spouses in continuing the methods. Urban women share family planning information with their husbands which they gather from the field workers. It seems that the field workers have played an indirect role to increase men's knowledge on family planning to a certain extent. It is important to enhance men's knowledge of female contraceptive methods to

encourage appropriate choices and continuation. The relevant target groups for counseling are primarily men who are currently married, including newly weds and secondarily those, who could be married soon, such as older adolescents. The mass campaign on radio, TV, and cinema halls can be introduced. At the community level, group or individual discussions can be organized at the men's workplace for this purpose. Improved leaflets on female methods aimed at men and how men can help their wives in contraception can be introduced. The pharmacists and shop owners can play an important role in disseminating the basic messages, and for this purpose they should get training on this issue. The community leaders can be involved and get training on family planning. The ways in which more detailed information about specific methods could be conveyed to men should be explored.

There is a great deal of misconception regarding modern male methods among urban men, which also prevents them from taking the initiative in using contraception. This requires individual counselling, as expressed by both men and women. A large number of misconceptions and apprehensions may be most effectively addressed through interpersonal interaction where men are assured of privacy and can gain adequate information. It is important to enhance men's knowledge of modern male contraceptive methods to encourage their practices. Dually, some issues also need to be examined carefully. Men recounted how condoms leak, cause allergy, and also the adverse post-operative effects of vasectomy. Further research is necessary to investigate the quality of family planning services and support systems. Quality control in storage and damage prevention of condoms and surgical skills in performing vasectomies would also play a part in rumours and misconceptions that lead to reluctance in using modern male contraception.

Considering the cultural context, male counsellors at the community level or group of men users are deemed most suitable for the task, and therefore, should be given specialized training on reproductive health

technology and counselling skills. Different group meetings with the community male members can be organized at their working place. The male method users can participate in the group meeting and share their experiences regarding the modern male method use. Referral networks would be necessary to enable men to have access to information and contraception services. Leaflets on condoms need to be reviewed, and simple pictorial one with more detailed information should be developed. At present the field workers distribute condoms with no such instruction sheet. The improved leaflet should be supplied in each condom packet distributed by the field workers at door step. In different areas, especially the slum areas, the clients face problem in storing condoms. Considering the practical situation, the possibility of improving condom materials needs to be explored. The quality of modern male methods (condom and vasectomy) service delivery needs to be ensured and monitored. The mass campaign on radio, TV and cinema halls may be emphasized.

An informed public in the urban areas represents a setting conducive toward motivating men to improve achievements of a programme that largely attributes its past and present success to targeting women. The suggestions and ideas of the urban community to increase modern male method use will be useful in developing motivational strategies. The findings of the study justify exploring ways to expand choices for urban couple to achieve reproductive health goals.

In short, the overall findings suggest two major areas with policy implications for enhancing urban men's participation in modern contraception. The first is related to the overall need to increase general education on modern male methods and promote their use. Action in this area would imply activities, such as:

a. reviews of current educational materials and instructions about modern male and female contraceptive methods and make

recommendations to enable men to support women in appropriate decision-making and continuation of contraceptive use;

b. extensive use of the mass media to popularize male role models that support and promote modern male contraception;

c. production of programmes that educate on family planning and, at the same time, are a source of entertainment;

d. development of family life training materials to use with the various target groups, including promotional materials, for use in the workplace; and

e. encourage involvement of manufacturers of contraceptives in sponsoring the production of materials and training activities.

The second area for action refers to the actual provision of contraceptive services to men. In this respect, the findings suggest the following activities which require policy decisions:

a. recommend quality control studies that investigate storage and distribution of condoms;

b. enhance good practice in counselling and in the surgical procedures for vasectomies;

c. training of clinic staff for communication activities with males on reproductive health;

d. production of appropriate training materials for use with pharmacists and shop owners;

e. explore the implication (costs and logistics) of employing male counsellors for family planning.

References

Aziz KMA, Maloney C. (1985) Life stages, gender and gertility in Bangladesh. Dhaka: International Centre for Diarrhoeal Disease Research, Bangladesh.

Bernhart M, Uddin MM. (1990). Islam and family planning acceptance in Bangladesh. Stud Fam Plann 21(5): 287-92.

Donahoe D. (1995) Men and family planning in Bangladesh: a review of the literature (draft). Dhaka: The Population Council, Bangladesh.

Davies J, Mitra SN, Schellstede WP. (1987) Oral contraception in Bangladesh: social marketing and the importance of husbands". Stud Fam Plann 18:157.

Ezeh AC. (1993) The influence of spouses over each other's contraceptive attitudes in Ghana". Stud Fam Plann 24(3):163-74.

Ezeh AC, Seroussi M, Raggers H. (1996). Men's fertility, contraceptive use, and reproductive preferences. Calverton, MD: Macro International Inc.

Faisel AJ, Ward V, Landry E, Mehta M. (1995) Vasectomy decision-making in Bangladesh. AVSC International.

Folmar S, Alam SMN, Sharif AHMR. (1992) Condom use in Bangladesh: final report. Dhaka: Social Marketing Company.

"Future challenges in the FP-MCH programme: a plan for action". (1994). Dhaka: Ministry of Health and Family Welfare.

Gallen ME, Liskin L, Kak N. (1986) Men - new focus for family planning program. Pop Rep Series J(.33).

Ginn TM, Bamba A, Balma M. (1989) Male knowledge, use and attitudes regarding family planning in Burkina Faso. Int Fam Plann Persp, 15(3): 84-7.

Islam MN, Rahman MM. (1993) Client satisfaction with sterilization procedure in Bangladesh. Asia-Pacific Pop J 8(1): 39-54.

Mazumder MA. (1993) Family planning from a male perspective in a Muslim society: a study in Chandpur, Bangladesh. Thesis prepared for Degree of Master of Science in Primary Health Care at the Flinders University of South Australia.

Mitra SN, Ali MN, Islam S, Cross AR, Saha T. (1994) Bangladesh demographic and health survey 1993-1994. Dhaka: NIPORT.

Mustafa MAB, Mumford SD. (1984) Male attitudes towards family planning in Khartoum, Sudan. J Biosoc sci, 16:437.

Oni GA, Carthy JM. (1991) Family planning knowledge, attitudes and practices of males in Ilorin, Nigeria. Int Fam Plann Persp, 17(2): 50-3.

Report of the International Conference on Population and Development. (1994). Cairo: Egypt.

Ringheim K. (1993) Factors that determine prevalence of use of contraceptive methods for men. Stud Fam Plann Mar-Apr; 24 (2):87-99.

Ross JA, Huber DH. (1983) Acceptance and revalence of vasectomy in developing countries". Stud Fam Plann 14 (3): 67-73.

Salway S, Jamil K, Nahar Q. (1993) Issues for family planning in urban slums of Dhaka, Bangladesh: opinions and perceptions of field-level workers. Dhaka: International Centre for Diarrhoeal Disease Research, Bangladesh (Urban FP/MCH Working Paper No.9).

MCH-FP Extension Work at the Centre

An important lesson learned from the Matlab MCH-FP project is that a high CPR is attainable in a poor socioeconomic setting. The MCH-FP Extension Project (Rural) began in 1982 in two rural areas with funding from USAID to examine how elements of the Matlab programme could be transferred to Bangladesh's national family planning programme. In its first years, the Extension Project set out to replicate workplans, record-keeping and supervision, within the resource constraints of the government programme.

During 1986-89, the Centre helped the national programme to plan and implement recruitment and training, and ensure the integrity of the hiring process for an effective expansion of the work force of governmental Family Welfare Assistants. Other successful programme strategies scaled up or in the process of being scaled up to the national programme include doorstep delivery of injectable contraceptives, management action to improve quality of care, a management information system, and developing strategies to deal with problems encountered in collaborative work with local area family planning officials. In 1994, this project started family planning initiatives in Chittagong, the lowest performing division in the country.

In 1994, the Centre began an MCH-FP Extension Project (Urban) in Dhaka (based on its decade long experience in urban health) to provide a coordinated, cost-effective and replicable system of delivering MCH-FP services for Dhaka urban population. This important event marked an expansion of the Centre's capacity to test interventions in both urban and rural settings. The urban and rural extension projects have both generated a wealth of research data and published papers.

The Centre and USAID, in consultation with the government through the project's National Steering Committees, concluded an agreement for new rural and urban Extension Projects for the period 1993-97. Salient features include:

- To improve management, quality of care and sustainability of the MCH-FP programmes
- Field sites to use as "policy laboratories"
- Close collaboration with central and field level government officers
- Intensive data collection and analysis to assess the impact
- Technical assistance to GoB and NGO partners in the application of research findings to strengthen MCH-FP services.

The Division

The reconstituted Health and Population Extension Division (HPED) has the primary mandate to conduct operations research to scale up the research findings, provide technical assistance to NGOs and GoB to strengthen the national health and family planning programme.

The Division has a long history of accomplishments in applied research which focuses on the application of simple, effective, appropriate and accessible health and family planning technologies to improve the health and well-being of the underserved and population-in-need. There are several projects in the Division which specialize in operations research in health, family planning, environmental health and epidemic control measures which cuts across several Divisions and disciplines in the Centre. The MCH-FP Extension Project (Rural), of course, is the Centre's established operations research project but the recent addition of its urban counterpart - MCH-FP Extension Project (Urban), as well as Environmental Health and Epidemic Control Programmes have enriched the Division with a strong group of diverse expertise and disciplines to enlarge and consolidate its operations research activities. There are several distinctive characteristics of these endeavors in relation to health services and policy research. First, the public health research activities of these Projects focus on improving programme performances which has policy implications at the national level and lessons for international audience. Secondly, these Projects incorporate the full cycle of conducting applied programmatic and policy relevant research in actual GoB and NGO service delivery infrastructures; dissemination of research findings to the highest levels of policy makers as well as recipients of the services at the community level; application of research findings to improve programme performance through systematic provision of technical assistance; and scaling-up of applicable findings from pilot phase to the national programme at Thana, Ward, District and Zonal levels both in the urban and rural settings.

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