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**Male Involvement in
Reproductive Health
Services in Bangladesh:
A Review**

**Ali Ashraf
Thomas T Kane
Ahsan Shahriar
Barkat-e-Khuda**



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Glossary

AHI	Assistant Health Inspector
AIDS	Acquired Immuno Deficiency Syndrome
ANC	Antenatal Care
AVSC	Access to Voluntary Safe Contraception
BCC	Behaviour Change Communication
BCCP	Bangladesh Centre for Communication Programmes
BDHS	Bangladesh Demographic and Health Survey
BRAC	Bangladesh Rural Advancement Committee
BWHC	Bangladesh Women Health Coalition
CA	Clinic Aid
CIDS	Centre for Integrated Development Studies
CM	Community Mobilizer
COPE	Client-oriented Provider Efficient
CPD	Center for Population and Development
CSP	Child Survival Programme
DFP	Directorate of Family Planning
DHS	Demographic and Health Survey
EOC	Emergency Obstetric Care
ESP	Essential Services Package
FPIs	Family Planning Inspectors
FWAs	Family Welfare Assistants
GoB	Government of Bangladesh
HA	Health Assistant
H&FWC	Health and Family Welfare Centre
HIV	Human Immune-deficiency Virus
HPSP	Health and Population Sector Programme
ICDDR,B	International Centre for Diarrhoeal Disease Research, Bangladesh
ICPD	International Conference on Population and Development
IEC	Information, Education and Communication
LSD	Laboratory Sciences Division
MCH	Maternal and Child Health
MWRA	Married Women of Reproductive Age
NAC	National AIDS Committee

Glossary (Contd.)

NIPORT	National Institute of Population Research and Training
NIPHP	National Integrated Population and Health Programme
NSV	Non-Scalpel Vasectomy
OTEP	Oral Therapy Extension Programme
PNC	Postnatal Care
PHSD	Public Health Sciences Division
RSDP	Rural Service Delivery Partnership
RTI	Reproductive Tract Infection
SACMO	Sub-Assistant Community Medical Officer
SBSP	Social and Behavioural Sciences Programme
SCs	Satellite Clinics
SMC	Social Marketing Company
STD	Sexually Transmitted Diseases
THC	Thana Health Complex
USAID	United States Agency for International Development
UFHP	Urban Family Health Partnership
VHSS	Voluntary Health Services Society

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Abstract

Background: Men as important decision-makers and collaborators in the process of reproduction have neither received an adequate attention nor have been investigated extensively. In the context of reproductive health, men are identified as an under-served demographic group in the national Health and Population Sector Programme (HPSP) and in the National Integrated Population and Health Programme (NIPHP) of Bangladesh.

Objectives: Recent attention on men as important candidates for reproductive health services warranted the need for a reviewing the past experiences in relation to male involvement initiatives. This review was undertaken to suggest strategies to increase men's supportiveness to their families in reproductive health services in Bangladesh.

Methodology: Published national and international literatures were reviewed. Field visits were made to projects on different male involvement initiatives undertaken by government and non-government organizations (NGOs). Besides, informal discussions were held with programme managers, male front-line supervisors, and selected males.

Findings: Results of the review show that the use of strictly male family planning method, such as condom, vasectomy and withdrawal as an indicator of male involvement in family planning, does not show much promise as the relative share of male methods has rather declined steadily from 22 percent of all method use in 1975 to only 14 percent in 1996-1997 in Bangladesh. Limited data on other selected indicators of male involvement in reproductive health show that men's approval for family planning is very high, and their family desires are quite similar to those of their wives, but they have an important role in healthcare seeking. The awareness about acquired immuno deficiency syndrome (AIDS) is higher among men than women; it is still quite low, with only about one-third of men ever having heard of AIDS and a much lower proportion knowing how it is actually transmitted. Some sexually transmitted diseases (STDs), such as syphilis and gonorrhoea, are prevalent among men.

To date, most male involvement initiatives have focused three major areas, such as (i) promotion of male contraception and safer sexual practices to prevent STDs and AIDS, (ii) establishment of male-only sexual health clinics or holding separate clinic hours for males and carrying out of studies on the prevalence of STDs, and (iii) treatment-seeking behaviour by men. However, many areas of

reproductive health issues are yet to be investigated extensively. These include men's interest, opportunities to take the responsibility in identifying and seeking qualified medical consultation for their wives' pregnancy or delivery-related complications, and taking their children for routine immunization. The areas of investigation are limitless, for example, the extent of negotiation the women can make with their husbands to prevent unwanted pregnancy or STDs.

The review also shows that men are unaware of their role as a supporting partner on reproductive health issues. Men's use of reproductive health services from the government and NGO facilities is low. They rather prefer to use private sources for their health and family planning needs. Service providers often fail to include male partners in the treatment and management of STD/reproductive tract infection (RTI) clients. Whatever efforts made so far by the government and NGOs under the name of "male involvement" have addressed only part of the problem. Moreover, very few messages address the male reproductive health issues. Documentation, monitoring, and evaluation of male involvement efforts are also insufficient.

Conclusions: The findings of this review are expected to be useful in developing appropriate strategies aiming at improving men's knowledge about reproductive health issues and services, increasing the use of reproductive health services by men, increasing supportiveness among husbands for the reproductive health of their wives and preventing STDs/AIDS in Bangladesh.

Introduction

Women bear many health burdens, such as child-bearing, fertility regulation and associated contraceptive side-effects, and recourse to abortion as a consequence of non-use of contraceptives or method failure. Thus, married women of reproductive age (MWRA) have been the primary focus of reproductive health research and programme interventions. In the past, programmes had focused on demographic and target-oriented objectives with very little emphasis on quality issues. Programmes have also failed to address the relations among men and women and their responsibilities [1]. Therefore, the role of men in reproductive health and their responsibilities as important decision-makers in the process of reproduction have neither received an adequate attention nor have been investigated extensively. This is primarily because a man's reproductive life-span is not as clearly defined as that of a woman. Moreover, women generally remain at home more than men [2]. Males are, thus, a more difficult group to target for programme intervention.

Man plays a key role socially and economically—first as a husband, then as a father—in the formation of the family, in child education, and in the health and nutrition of the family members. A husband is also required to be supportive of the decisions and needs pertaining to the reproductive health of his wife. There is evidence that not only couples, but also men and women of the extended families participate in fertility and in decision-making of contraceptive use [1].

Following the International Conference on Population and Development (ICPD) held in Cairo in 1994, and the Fourth World Conference on Women held in Beijing in 1995, globally, there has been an increased recognition of the need for men to share more responsibility in reproductive health matters by taking a more active role in planning pregnancy, seeking healthcare in case of adverse pregnancy outcomes and in preventing sexually transmitted diseases (STD), reproductive tract infections (RTI), human immune-deficiency virus (HIV) infections, and acquired immuno deficiency syndrome (AIDS).

Males have only recently been receiving attention as important candidates for reproductive health services because of their own health and because their sexual behaviours affect the reproductive health of their female partners. The role men play as partners has different connotations and can vary widely between different subcultures and social strata. This is partly because men and women can be involved sexually without actually being married, and can also have multiple sexual partners before marriage, within marriage, or outside marriage. Men may too suffer from reproductive ill-health, particularly from STDs and HIV/AIDS. Thus, while recognizing that the main burden of reproductive ill-health falls on women,

strategies to improve reproductive health must also take into account the concerns, needs, roles and responsibilities of males [3,1].

The purpose of this review is to present a review on male involvement initiatives in the past, so that the experiences can be used for developing appropriate strategies for the national programme aiming at (a) improving men's knowledge about reproductive health issues and services, (b) increasing the use of reproductive health services by men, (c) increasing supportiveness among husbands for the reproductive health of their wives, and (d) preventing STDs/AIDS.

Problem Statement

Because of heavy emphasis of the past programmes on family planning (FP), the use of male methods, such as condom, vasectomy, and withdrawal, has long been considered as an indicator to describe "male involvement" and "male participation" in FP. Other commonly used terms are "male responsibility," "men's programme," and "men as partners." Two international conferences mandated that men's constructive roles be made part of the broader reproductive health agenda [4]. Despite academic debate on these terms, male responsibility in reproductive health has been identified as a prominent area of research and programme intervention.

Men's "reproductive responsibilities" are a stronger term which implies that men are obligated to carry out certain activities and can, therefore, be held accountable for their actions [1]. To clarify, the ICPD Program of Action notes, "Special efforts should be made to emphasize men's shared responsibility and promote their active involvement in responsible parenthood, sexual and reproductive behaviour, including family planning; prenatal, maternal and child health; prevention of STDs, including HIV; and prevention of unwanted and high-risk pregnancies" [5]. Such a conceptualization has broadened the role of men in reproductive healthcare well beyond their participation in fertility control.

In the context of reproductive health programmes and services, men play a prominent role as the top-level policy-makers, programme managers and service providers [6]. In light of the ICPD definitions and policy recommendations, the Government of Bangladesh (GoB) has formulated a Fifth Health and Population Sector Programme (HPSP) in which reproductive health services will be implemented under an Essential Services Package (ESP) to improve family health. The non-government organizations (NGOs) under the National Integrated Population and Health Programme (NIPHP), funded by the United Agency for International Development (USAID), have also included reproductive health in their future service-delivery strategies. Men, along with other special groups, such as adolescents, non-pregnant and non-lactating women and peri-menopausal

women, have been identified as under-served demographic groups under the HPSP and the NIPHP [7,8].

The term under-served means that appropriate services are seldom available at the existing programme's outlets and that when services are available, they are not fully used. Thus, males have become an under-served group for many reasons—both programmatic and cultural.

Despite Bangladesh's remarkable achievement in raising the overall prevalence of contraceptive use, it has still been ranked as "weak" alongside India, Nepal and the Philippines with regard to measures to promote male involvement, shared responsibility, and supportiveness in decision-making about and use of FP methods and other reproductive health services. The situation is much favourable in Indonesia compared to Bangladesh [9]. Although the majority of men approve of family planning and have fertility desires similar to those of their spouses, men are less positive toward the actual practice of male contraceptive methods. Preference for sons seems to be common among urban men, although they do not necessarily want large families [10]. With regard to son preference the situation is quite similar in the rural areas. Men also lack awareness of their potential role as a supportive partner in women's reproductive health. An inadequate knowledge among males about fertility regulation, pregnancy and child-bearing can lead to abortion and maternal death. However, the extent of men's involvement in responsible parenthood can easily be summarized, from the available national demographic and health surveys carried out in Bangladesh. According to the Bangladesh Demographic and Health Survey (BDHS), 1996-1997, the prevalence of strictly male method use (i.e. condom, vasectomy, and withdrawal) was 6.9 percent—about 14 percent of all method use [11]. A seven-fold increase in the use of female methods has occurred during the past 20 years. During the same period, the use of male methods has not increased substantially, and the relative share of male methods has rather declined steadily from 22 percent of all method use in 1975 to 14 percent in 1996-1997 (Table 1).

Table 1. Trends (%) in current use of family planning methods

Methods	1975 BFS	1983 CPS	1985 CPS	1989 BFS	1991 CPS	1993-94 BDHS	1996-97 BDHS
Vasectomy	0.5	1.2	1.5	1.2	1.2	1.1	1.1
Condom	0.7	1.5	1.8	1.8	2.5	3.0	3.9
Withdrawal	0.5	1.3	0.9	1.8	2.0	2.5	1.9
Total male methods	1.7	4.0	4.2	4.8	5.7	7.6	6.9
Periodic abstinence	0.9	2.4	3.8	4.0	4.7	4.8	5.0
Total female methods	5.1	12.7	17.3	22.0	29.5	33.2	37.3
Any method	7.7	19.1	25.3	30.8	39.9	44.6	49.2

BFS Bangladesh fertility survey

CPS Contraceptive prevalence survey

BDHS Bangladesh demographic and health survey

Although condoms were positively viewed by some men, most men found it to be undependable and physically disagreeable [12]. It would be an error, however, to limit any assessment to this type of indicator, since the use of male contraceptive methods is only one of several indicators of male involvement in reproductive health.

Very limited information is available about men's knowledge, attitudes and practices with regard to STDs and the males' role in maternal and child healthcare (MCH). Nevertheless, it would be valuable to examine the extent to which men participate in all aspects of family health, including their own. With regard to maternal health, knowledge among men about pregnancy and obstetrical complications is undetermined, as is the male role in MCH care support offered by the husband for his wife's seeking of FP consultation, antenatal care (ANC), delivery, and postnatal care (PNC).

Some limited data on male awareness and involvement in reproductive health are available from the last two BDHS and several sub-national-level surveys which show that (a) men play an important role in FP and healthcare decision-making; (b) male approval of FP is now very high; (c) family desires among men are quite similar to those of their wives; and (d) although awareness about HIV/AIDS is higher among men than women, it is still quite low—with only about one-third of men ever having heard of AIDS and a much lower proportion knowing how it is actually transmitted (Table 2).

Table 2. Patterns of male awareness, decision-making, and involvement in reproductive health

Selected indicators	1993-1994	1996-1997
1. Family planning		
Husband prefers contraceptive use ¹	12%	29%
Husband does not approve of contraceptive use ¹	8%	4%
Husband wants more children, but wife does not ¹	6%	3%
Discontinued contraceptive method due to husband's disapproval ¹	7%	4%
Discontinued contraceptive method due to side-effects ¹	34%	37%
Husband unwilling to use method due to wife's side-effects ²	N/A	70%
Husband did not agree to use method after wife requested ²	N/A	63%
2. STD/AIDS awareness and transmission		
Men had heard about AIDS ¹	N/A	33%
Men had heard about AIDS ³	N/A	40%
Men had heard about AIDS ⁴	N/A	19%
Women had heard about AIDS ¹	N/A	16%
Women had heard about AIDS ³	N/A	20%
Women had heard about AIDS ⁴	N/A	7%
Women had heard about AIDS ⁵	N/A	3%
Of the men who had heard about AIDS, percent who didn't know a way how to avoid getting it ¹	N/A	51%
Of the women who had heard about AIDS, percent who didn't know a way how to avoid getting it ¹	N/A	69%
Women had heard about gonorrhoea or syphilis ⁵	N/A	2%
Women knew about gonorrhoea or syphilis transmission ⁶	N/A	27%
3. Maternal health		
Husband makes decisions about curative care ⁷	N/A	34%
Husband accompanies wife for curative care ⁷	N/A	46%
4. Child health		
Children with ARI taken to health facility ¹	28%	33%
Husband makes decisions about child care treatment ⁷	N/A	25%
Husband accompanies child for care ⁷	N/A	34%

NA Not available

Source: ¹BDHS 1993-94, 1996-97 [11,13]

³Rahman M *et al.*, 1996 [15]

⁵Bhuiya A 1996 [17]

⁷Levin A *et al.*, 1997 [19].

²Neaz A *et al.*, 1996 [14]

⁴Fulton L *et al.*, 1994 [16]

⁶Khan A M *et al.*, 1996 [18]

To date, most involvement initiatives of male have focused on three areas: (a) the promotion of male contraception and safe sexual practices to prevent STDs and AIDS; (b) establishment of male-only sexual health clinics, or holding separate clinic hours for males; and (c) carrying out of studies on the prevalence of STDs and treatment-seeking behaviour by men. Some studies have examined husband-wife communication and decision-making in FP and other areas of reproductive health [20, 21].

Many questions still need to be addressed. Some questions are: in the current socio-cultural context, are men interested in sharing the responsibility of reproductive health with their partners? Are men adequately informed of reproductive health issues and are the services available to them? Do men have opportunities to take more responsibility under the existing service-delivery strategy? It is still unknown whether husbands are capable of identifying and seeking qualified medical consultation for their wives' pregnancy and/or delivery-related complications. How often do men take their children for routine immunizations, and to what extent can women negotiate with their husbands for using condoms to prevent pregnancy or STDs. The condom—the most widely available male method for both contraception and prevention of STDs, including HIV infection—remains largely under-used [22]. No studies on the prevalence of and reasons for infertility among men have been carried out in Bangladesh.

Under the current structure of the Bangladesh Health and Family Planning Programme, female field workers, referred to as Family Welfare Assistants (FWAs), primarily motivate the women to accept contraceptive methods. Consequently, the methods that are being widely accepted in Bangladesh are primarily female methods. With regard to the promotion of male methods, such as condom and vasectomy, it is again the responsibility of the FWAs to approach women. Studies have shown, that, in practice, the FWAs rarely mention these two methods to women. It is commonly known that the FWAs prefer not to approach men, since to do so is a breach of current sociocultural norms. Even the male health workers, known as Health Assistants (HA), prefer to approach women, because they are more often available in their homes during regular working hours.

Generally speaking, the present health and FP services, primarily targeted toward women and children, are provided by female workers and are available from the mobile Satellite Clinics (SCs) and the Health and Family Welfare Centres (H&FWCs) of the government as well as from the static clinics operated by the NGOs. Consequently, the SCs and the H&FWCs are viewed by men as places where females and children receive preventive and curative services. Thus, the current service-delivery strategy appears to have pushed men away from participating in reproductive health services of the government or NGOs. This

situation has reinforced the predominant cultural attitudes that men do not need to take any responsibility or initiative with regard to the reproductive health needs of the family. Nevertheless, sexual behaviour and health status of males affect female health, and the reproductive health need of males is not being adequately addressed.

Out-patient services are available at the Thana Health Complexes (THCs) which are equipped with facilities to address the problems of both men and women. But there are reasons to suspect that whether the issues surrounding reproductive health problems are clearly understood or not by the service providers at the THC level. Moreover, it is not adequately known whether men and women use this centre specifically for any reproductive health problems.

Till today, no major effort has been made to include men, an essential partner, in reproductive health services. Besides, all innovative attempts have been mainly made to increase the use of contraceptives by females. No efforts have virtually been made to raise awareness among the community people, particularly focusing on men in any systematic way to generate their supportiveness on reproductive health issues. All promotional meetings organized for this purpose have been held primarily at the district level, THC, or H&FWC. Social leaders have never been given any responsibility to advise and motivate men to be responsive on reproductive health issues, and there has been no systematic follow-up of limited initiatives in relation to their involvement.

Abundant information, education and communication (IEC) materials on FP, including condom and vasectomy, are available for dissemination and use. But there are very few materials that focus on men's responsibility. It has been observed that duplicated efforts have been made in producing multiple IEC materials covering the same topic, and the IEC materials supplied from the national head-quarter often end up at the office of the local programme managers. Only on various special occasions, they are hung on the wall of the THC or H&FWC. It is not clearly understood how the requirements for IEC materials are determined, and how they should be displayed—especially in rural settings.

Oral pill is the only contraceptive method prominently advertised on radio or television. Condom as a potential barrier method for both contraception and prevention of STD is not advertised in TV. Condoms are usually secretly sold at the pharmacies.

Methodology

Published national and international literatures were reviewed. Field visits were made to projects on different male involvement initiatives undertaken by government and non-government organizations (NGOs). Besides, informal discussions were held with programme managers, male front-line supervisors, and selected males.

Background

Review of Literature

Demographic studies on fertility and family planning have focused on women, but examined men from a narrow range of approach. The narrow range of approach in studying men reflects the fact that it has not been dealt consistently or well with the topic of gender. Men are now included in many national demographic health surveys, particularly due to the emergence of STD/HIV/AIDS which have major social concerns.

Very little is known about the reproductive health needs of men, since only a few small studies have been carried out on male sexual behaviour, describing male involvement in pre- and extra-marital sex and experience with STDs. And only limited information is available about where men go for diagnosis and treatment of STDs, treatment of perceived sexual dysfunction, or urological problems. Result of several studies show that *ayurvedic* practitioners, known as *kabiraj*, are often the primary contact persons for men for any conditions or problems relating to sexuality, followed by unqualified practitioners and pharmacy-based medicine-sellers [12].

A clinic-based RTI/STD study, carried out in 1995, found that only three percent of those visiting the clinic for RTI/STD problems were male. In fact, more than 27 percent of the clients who sought services for RTI were IUD users [23]. In 1996-1997, the former MCH-FP Extension Project (Rural) of the International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B) also explored the possibility of using male supervisors, i.e Family Planning Inspectors (FPIs), Assistant Health Inspectors (AHIs) and HAs to organize meetings of the males in the community to inform them about FP, pregnancy and delivery-related complications, risky sexual behaviour and condom use for prevention of STD/HIV/AIDS [24].

A study on the use of modern contraceptives among urban men found that men have little knowledge or understanding of female methods which prevents them from actively supporting their spouses in accepting, using or continuing to

use the methods effectively [10]. The males who were interviewed suggested to use the media to motivate other males, to provide privacy at service centres, and to provide individual counselling for males. Misconceptions about condoms and vasectomies contributed to their low use (common misconceptions included the fear of losing physical strength). The study also revealed that communication between husbands and wives has had major implications on the degree of male participation in FP.

The Population Council conducted a study of male clients visiting two male clinics in Dhaka for different services and found that 11 percent were STD clients and 28 percent were with other sexual health problems [25]. The serological evidence of a cross-sectional study on the prevalence of STDs among Dhaka slum dwellers showed that current syphilis infection was prevalent in 11.5 percent of the men and 5.4 percent of the women. The prevalence rate of both gonorrhoea and chlamydia was less than one percent and the hepatitis B surface antigen was present in 5.8 percent of the men and in 2.9 percent of the women [26]. Another community-based study suggested that both men and women perceived sexual or reproductive health problems are fewer among men. It also indicated that, in rural areas, men preferred first to consult unqualified practitioners for reproductive health problems [17]. According to one urban study, use patterns of health service among women and men differ; women seem to be confined to private, for-profit clinics, whereas men often just buy medicines at the pharmacy for some form of self-care [27]. Urban men also prefer to visit pharmacies for their STD-related problems [28].

Projects Relating to Male Involvement in Reproductive Health

In view of the increasing recognition of the need to involve men in women's healthcare, male involvement has become the topic of many and varied intervention activities in several countries. The Mother Care Strategy in Bolivia has produced some interesting results. This study found that husbands accompanied their wives to seek care during pregnancy and delivery [29]. Results of another comparative study of government and private practice in India showed that husbands accompanied their wives to the private facilities during ANC visit and that delivery doubled during the intervention period [30]. Another study conducted in Bombay reported, greater number of visits to maternal health centre was made by the women when their husbands had attended informal session at the clinic compared to the husband who did not attend [31].

During the mid-seventies, a mass male sterilization programme was conducted in Bangladesh aiming at increasing the relative share of male sterilization. Although such an effort resulted in an immediate increase in male

method use, the success could not be sustained due to an abrupt discontinuation of the programme strategy. To mobilize support for this programme, the services of male supervisors were used. Although a considerable success was achieved in the immunization programme, sustainable success could not be achieved in FP. On the other hand, several collaborative efforts were undertaken by the government with technical assistance from NGOs. These activities were focused mainly on FP which include a yearly reception for the recognition of the ideal couple (a two-child couple), observation of a monthly "husband day", introduction of a special hour at the H&FWC, improvement in the availability of non-scalpel vasectomy (NSV) and training/orientation of the government managers, community, religious and political leaders.

A government task force and the National AIDS Committee (NAC) have already formulated 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 behaviour and supply of condoms; case management throughout the public and private general health system, including first-level healthcare; the use of simple algorithms based on syndromic diagnosis; the inclusion of STD care in MCH services; the targeting of STD care services to populations identified as at an increased risk; and the promotion of STD-related and other sexual healthcare-seeking behaviour-related education [32]. Efforts to increase clinical contraception include the promotion of vasectomy services.

The Public Health Sciences Division (PHSD) of the ICDDR,B has been carrying out studies on the prevalence of STDs/RTIs among men and women, and has established a sexual health clinic for men at Matlab. The community-based survey in Matlab reported a five-percent prevalence of chlamydial trachomatis among men. Fifty-seven percent of the men in the study had pre-marital sex, 18 percent presented payment for sex, and 8 percent had sex with men. According to this study, men experienced pain when passing urine, urethral discharge, painful coitus and genital ulcer [33]. This clinic-based study suggests that men report STD symptoms quite freely in the clinic setting. The study also identified cases in which information on STDs provided by the service providers was not correct, and that they were often judgmental with regard to sexual behaviour. The activities of the Social and Behavioural Sciences Programme (SBSP) of PHSD include the preparation of training materials to address sexual health of young males and females aged 12-22 years, and a situation analysis of HIV/AIDS risks and prevention strategies for sailors at Chittagong Port City, homosexually active men and intravenous i.e. drug users.

The Laboratory Sciences Division (LSD) of ICDDR,B has been collaborating with the Bangladesh Women's Health Coalition (BWHC) clinic in Dhaka to study

the prevalence of RTIs/STDs and to plan for the sentinel surveillance of sex workers, i.e. drug users (mostly male), transport workers, and STD patients. The LSD is also planning to carry out a baseline surveillance study of HIV/AIDS among various high-risk groups of males and females.

Several NGOs, such as Access to Voluntary Safe Contraception (AVSC), Voluntary Health Services Society (VHSS), Family Planning Association of Bangladesh (FPAB), Paricharja, CARE, Nari Maitree, and Marie Stopes, have programmes of male involvement initiatives. These organizations have been working toward preventing and managing RTIs/STDs among males through offering services in the evening from specialized clinics run by male doctors; offering counselling with the use of both male and female counsellors working with male and female clients in separate rooms; introducing separate cards for men to strengthen partner management; distributing reading materials on the prevention of STDs/HIV/AIDS for the purpose of raising awareness among the male and female college and university students; and developing a system of referral and linkage using local drug shops to refer male customers to the clinic for RTIs/STDs.

To promote FP and RH issues, the FPAB has used canvassers, youth leaders, religious leaders, and traditional healers. One prominent IEC material produced by them has attempted to focus the issue of equal responsibility in both use of contraception by males and supporting contraceptive use by their wives [34]. Males are targeted as primary audiences for an innovative STD/AIDS prevention programme of the Social Marketing Company (SMC). Communication interventions include advocacy meetings, social mobilization activities, peer education, group meetings, counselling sessions, and film shows. Training sessions for pharmacists on information about STDs/HIV/AIDS and case management of STDs are also being carried out.

The Population Council, in collaboration with the Directorate of Family Planning (DFP) and the National Institute of Population Research and Training (NIPORT), has introduced various IEC materials, including "responsible parenthood", "non-scalpel vasectomy—an easy and safe procedure for males" and "why male involvement in family planning is necessary." The Population Council has also introduced special hours of operation at the H&FWC that better suit the males. These centres feature the use of male FPIs for couple orientation, special male-oriented IEC, and an increased availability of NSV in Kalihati THC of Tangail district. An outcome of the intervention has been a substantial rise in vasectomy acceptance and condom use in the project area [35].

The Pathfinder International has targeted the newly-wed couples to educate them about family planning, pregnancy care and safe delivery, and to enhance the role of husbands as a supportive partner in women's reproductive health. A major objective of the intervention is to convince both husband and wife to delay

pregnancy till the wife has reached the age of 20 years. The evaluation showed an increase in the contraceptive use among the newly weds by 36 to 41 percent and an increased participation of husbands in newly-wed orientations (although this was still quite low—from 5 to 12%) during the intervention period [36].

The Centre for Population and Development (CPD) has been implementing a male involvement initiative by using local folk media, FPIs, male volunteers, and canvassers to distribute condoms in public places and the observance of "Husband Day" on a monthly basis in Sonargaon thana of Narayanganj district. A poster entitled male involvement in family planning contained seven key messages was prepared and distributed. The messages include know family planning, accept family planning, know male method, use condom, discuss with your wife, make a planned family, and encourage other to accept family planning [37].

The Centre for Integrated Development Studies (CIDS) used the FPIs and community leaders for male mobilization through a client-segmentation approach. The CIDS's male motivation programme used the FPIs at the thana level. The main field interventions of this male involvement initiative were: (a) establishment of FPI and field worker-male client contact on a regular basis; (b) cluster meetings, involving 8-12 males from the same locality who are regularly visited in a school, club, or other social meeting places to discuss the message of reproductive health (sometimes including film shows and folk songs); (c) involvement of male community leaders and religious leaders in the promotion of reproductive health; and (d) selection of male volunteer motivators. The evaluation of this approach showed an increased acceptance of condoms in the treatment areas, but a reluctance to undergo vasectomy. Son preference was strong, and men lacked knowledge about traditional male methods, such as withdrawal and periodic abstinence [38].

The male involvement activities of the AVSC in Bangladesh include: (a) training of physicians in male sterilization services; (b) introduction of the NSV procedure; (c) provision of support for national workshops on male participation in FP; (d) understanding of research on vasectomy decision-making in Bangladesh; (e) use of a client-oriented provider-efficient (COPE) approach to improve the quality of male and female FP services; (f) training of providers on the importance of male involvement in FP; and (g) improvement of community support and male participation in FP through seminars; participants include the male house owners of SCs, cluster spots and immunization sites, Union Parishad chairmen and members, husbands of female FP staff, FPIs and selected male staff of health clinics and NGOs.

Although no dramatic changes in method mix were found, use of male methods continued to rise in the three project sites of the AVSC. According to the

study, problems relating to male involvement included: (a) lack of staff capable of delivering male reproductive health services; (b) lack of facilities necessary to deliver male services; (c) need for IEC that challenges many misconceptions and rumors about male methods; (d) lack of strong NGO and private sector services; and (e) lack of government support for male involvement in FP.

Some positive findings of all the efforts are as follows: (a) facilities for male FP services do exist at the GoB outlets; (b) there is a demand for male services, including vasectomy; and (c) most male leaders, male health workers, and spouses of female health workers in the community are supportive of FP and MCH activities.

The AVSC study recommended (a) orientation and training of health workers on male involvement in FP-MCH services; (b) promotion of vasectomy and condom use through IEC; (c) provision of services for males at SCs; and (d) raising awareness among community people about male reproductive health services.

Lessons Learned

The efforts that have been made so far by the government and NGOs under the name of male involvement address only part of the problem. The data available do not provide in-depth information on key issues concerning barriers, service inadequacies, needs, motivational factors or gender issues affecting the involvement of men in reproductive health. Nor do the data reflect the extent of male involvement in reproductive health services. Although the prevalence data relating to STDs and AIDS have yet to be firmly established, the available evidence suggests that STDs and RTIs are prevalent in both urban and rural areas. The review of work on male involvement by the GoB, NGOs and ICDDR,B suggests that men report STD symptoms quite freely in the clinic setting. It has also been observed that most men tend to use pharmacies, private and unqualified practitioners for treatment of STDs and other healthcare seeking. Although these providers are the first contact for treating STDs and they often over prescribe, their role should be considered in the design of male involvement interventions. Because information on STDs provided by the healthcare providers is not always correct, and these workers are often judgmental with regard to sexual behaviour. Thus, service providers need to be trained in counselling and treatment. Key informants suggested that motivational meetings with local leaders at the male work sites could be a means to persuade more men to use contraceptives. Some IEC print materials on male health issues are available. There is a very little coverage, however, of male reproductive health issues in the mass-media (TV, radio, newspapers). Moreover, documentation, monitoring and evaluation of male involvement efforts are insufficient.

The role of men in supporting their partners in attaining reproductive health needs to be strengthened. The knowledge of men could be improved by supplying them a package of targeted IEC materials on a broader range of reproductive health issues. Although it is difficult to organize sessions on reproductive health for males in public places, services of the well-trained, motivated FPIs/AHIs can be used for communicating reproductive health messages to men. Reproductive health services should be available from the local-level health facilities which in itself would improve access and use by men. However, services should be made available from different service outlets. Healthcare providers, due to lack of orientation, often fail to include male partners in the management of RTI/STD clients. Health facilities of the government and NGOs below the thana level are not adequately equipped to provide reproductive health services for men. Men can be reached for reproductive health services through employment-based services, social marketing, pharmacies, and private clinics for males on special days or hours at the government and NGO health facilities. Advertisement and motivation through radio and television will be necessary to create awareness among urban men to use contraceptives at an increased level. IEC and counselling strategies for men need to be segmented by audience (e.g. marital status, life stage, location—urban vs. rural—educational level and occupation).

Future Directions

Results of the review show that appropriate strategy to target men for reproductive health is yet to be identified and their potential role as a supportive partner to their wives is crucial to the improvement of family health. Although Bangladesh Rural Advancement Committee (BRAC) has successfully reached men to provide education on oral therapy extension programme (OTEP) and child survival programme (CSP), mobilizing men around reproductive health issues will, however, require a very different approach than that used for the OTEP [39].

Considering the sensitivity of the topics included in reproductive health, an in-depth qualitative assessment of perception, knowledge, attitude and practice of selected males (client, social leaders, and providers) could provide more insights about male interest in reproductive health issues and services.

Very limited and systematic attempts have been made in the past to use the services of available male supervisors to stimulate male involvement. The programme managers of the most service-providing organizations tend to think of reproductive health simply as a set of preventive measures, diagnoses and treatment of RTIs and STDs [40].

A well-designed male focussed 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 among husbands for the reproductive health of their wives and preventing STDs/AIDS should be undertaken. The male focused Male Motivation Project in Zimbabwe has demonstrated an increase in the percentage of men favouring joint decision-making in FP [41].

IEC interventions should be directed to use social elite, such as, Union Parishad (UP) chairmen, UP members, school teachers, other formal and informal leaders, interested religious leaders and popular village practitioners to promote the issues of reproductive health and the responsibility of men.

The potential of using three male HAs and two male supervisors, namely AHI and FPI, and a SACMO at the lowest operational level of the government is yet to be explored systematically. Male supervisors also lack clear instruction; they are not aware, which men should be targeted; for what purpose; and how to go about targeting them. Therefore, male supervisors should be given the specific assignment of targeting a specific group of males in a clearly-defined setting, and the activities must be measurable. In view of changes in the national service-delivery strategy, the role of the HAs is likely to change. This will leave two male supervisors and one SACMO available to play an active role on the issue of male involvement in reproductive health.

The service-delivery strategy, followed by Rural Service Delivery Partnership (RSDP), has an average of three community mobilizers (CM) under each static clinic catchment area. The majority of them are males, and have the potential to take up the issues of male involvement.

The service-delivery strategy, followed by Urban Family Health Partnership (UFHP), has female service promoters with similar job responsibilities as the CM of RSDP.

In addition to community-based male focussed IEC effort, there is a need to orient the service providers about the role of men in improving family health, increase their knowledge on the prevention and management of reproductive health problems and prepare the service-providing facilities for offering reproductive health services simultaneously.

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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. In 1982, the MCH-FP Extension Project (Rural) with funding from USAID began to examine in rural areas how elements of the Matlab programme could be transferred to Bangladesh's national family planning programme. In its first year, the Extension Project set out to replicate workplans, and record-keeping and supervision systems, 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, management information systems, and 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.

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: improving management, quality of care and sustainability of the MCH-FP programmes, and providing technical assistance to GoB and NGO partners. 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 in international scientific journals.

In August 1997 the Centre established the Operations Research Project (ORP) by merging the two former MCH-FP Extension Projects. The ORP research agenda is focussed on increasing the availability and use of the high impact services included in the national Essential Services Package (ESP). In this context, ORP has begun to work with partners in government and NGOs on interventions seeking to increase coverage in low performing areas and among underserved groups, improve quality, strengthen support systems, enhance financial sustainability and involve the commercial sector.

ORP has also established appropriate linkages with service delivery partners to ensure that research findings are promptly used to assist policy formulation and improve programme performance.

The Division

The Health and Population Extension Division (HPED) has the primary mandate to conduct operations research, to disseminate research findings to program managers and policy makers and to provide technical assistance to GoB and NGOs in the process of scaling-up research findings to strengthen the national health and family planning programmes.

The Division has a long history of solid 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 underserved and population-in-need. There are various projects in the Division which specialize in operations research in health, family planning, environmental health and epidemic control measures. These cut across several Divisions and disciplines in the Centre. The Operation Research Project (ORP) is the result of merging the former MCH-FP Extension Project (Rural) and MCH-FP Extension Project (Urban). These projects built up a considerable body of research and constituted the established operations research element for child and reproductive health in the Centre. Together with the Environmental Health and Epidemic Control Programmes, the ORP provides the Division with a strong group of diverse expertise and disciplines to significantly consolidate and expand its operations research activities. There are several distinctive characteristics of these endeavors in relation to health services and policy research.

For one, the public health research activities of these Projects are focused on improving programme performance which has policy implications at the national level and lessons for the international audience also. Secondly, these Projects incorporate the full cycle of conducting applied programmatic and policy relevant research in actual GoB and NGO service delivery infrastructure, 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 program performance through systematic provision of technical assistance; and scaling-up of applicable findings from pilot phase to the national program at Thana, Ward, District and Zonal levels both in the urban and rural settings.



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