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Male Involvement in Bangladesh's Reproductive Health Programme: A Status Report

Author: Tehmina Ghafur
Affiliation: Department of Population Sciences, University of Dhaka
Corresponding author/address: Tehmina Ghafur, Department of Population Sciences, University of Dhaka, Bangladesh

Introduction

The issue of men's involvement in reproductive health services emanates from the underlying inequalities and inequities in the established gender-specific roles and responsibilities of men and women. Gendering of the roles and responsibilities tends to disengage men from core areas at the family and societal level (e.g., general health and nutrition, reproductive health, child care). Disengagement excludes men from participating and sharing responsibility in core areas of their life. Such exclusion is thought to be a major source of many gender-specific inequalities and inequities.

Since its inception in the 1960s, the family planning programme (FPP) has primarily ignored men (Drennan, M., 1998). Since women bear the risk of pregnancy and child birth, FPP have assumed women have the greatest stake in protecting themselves against unwanted pregnancy. In the 1980s FPP started giving limited attention to men through workplace programmes and condom social marketing (Drennan, M., 1998). Focus of male involvement was then limited to promotion of male contraceptives. Population planners promoted men's participation as family planning method acceptors in order to ensure sustained use of contraceptive methods. On the other hand, feminists promoted men's inclusion in the FPP with the hope that such inclusion would lead to a situation where men would shoulder the responsibility of contraception.
In the 1990s, the concept of male involvement was intensified in the wake of the HIV/AIDS pandemic. It was understood that the dominance of men in every sphere of life demanded the inclusion of men in sexual and reproductive health programmes (RHPs). Efforts to include men in RHPs were intensified during the 1990s. Intensified efforts to include men in RHP were taken in the wake of rising apprehension about HIV/AIDS and other STIs; increasing reports and information on ill effects on women and children resulting from some men's risky sexual behaviour; growing recognition that in many societies men make critical decisions that affect the reproductive health of women; and an increasing awareness that gendered roles affect sexual behaviour, reproductive decision making, and reproductive health in many ways (Drennan, M., 1998).

In 1994, the International Conference on Population and Development (ICPD) gave momentum to the concept of male involvement in RHP. After ICPD, male involvement in RHP gained popularity in many countries. The concept of "male involvement" that resulted from ICPD was wide-ranging, with the intention of addressing gender inequality and inequity in all aspects of reproductive health. The Platform of Action of the Fourth World Conference on Women, in 1995,

followed the same tone with regard to the role of men in promoting reproductive health. Initiatives taken by many countries to incorporate and promote male involvement in reproductive health, however, failed to grasp the profundity and spirit of the concept of involving men in many ways. Only recently has the issue of male involvement received due attention in RHP and policies in Bangladesh. However, this prioritization of male involvement has been conceived from a very narrow perspective. Such a narrow conceptualization is likely to have serious implications for the health of both men and women.

In this report, male involvement initiatives in Bangladesh, both past and present, are critically examined, and the prospect of fully involving men in RHP in Bangladesh is explored. The report is based on review and analysis of the male involvement approach and associated initiatives by the RHP of the government of Bangladesh.

Male Involvement Initiatives in the RHP of Bangladesh

The RHP of Bangladesh has its legacy in the family planning programme of the 70s and 80s. The family planning programme (FPP) had remarkable success with respect to bringing down fertility level from 6.3 births per woman in 1975 to 3 births per woman in 2004 (NIPORT, 2004). Over the last three decades, use of any method of contraceptive by married women has increased from 8 to 58 percent and use of modern methods of contraceptives by married women has increased almost tenfold, from 5 to 47 percent (NIPORT, 2004). One of the major reasons for the success of the FPP in reducing fertility was its women-centered-door-to-door-service-delivery approach (Schuler, S. R. et al., 1995; Piet-Pelon, N. J., et al. 1999). Large numbers of Family Welfare Assistants (female field workers) were deployed at the community level to reach women at their home. This was a revolutionary step for Bangladesh. According to Perry (2000), female field workers were employed to make home visits to married women of reproductive age for promoting contraceptives (mainly pills and condoms) and also for promoting basic maternal and child health services such as immunization services, referrals for antenatal care, use of oral dehydration fluids for diarrhea, among others. Deployment of female field workers had several intended and unintended results. All married women of reproductive age had very easy access to family planning information and services. These female field workers were key role players behind the success of Bangladesh's immunization and diarrhea programme. Employment of female field workers greatly contributed to an increase in the mobility of women in rural Bangladesh (Piet-Pelon, N. J., et al. 1999).

An unintended outcome of the strategy of deployment of women field workers was the isolation of men from the programme (Piet-Pelon, N. J., et al. 1999). Prevailing cultural norms prohibited them to communicate with women outside their kinship structure. Male workers were also no longer actively involved at the community level. Moreover, family planning services were so easily available to women that men started to withdraw their active interest in contraception (Piet-Pelon, N. J., et al. 1999). This isolation perpetuated the feeling among men that they had no role to play in family planning and maternal health. The strategy of excluding men from the FPP simply reinforced the already existing gendered roles in the reproductive function and process. Schuler et al. (1995) argued that the women-centered approach in Bangladesh accommodated gender-based inequality rather than addressing it. This women-centered approach placed the responsibility of family planning disproportionately on women who lack the resources to deal with its costs and risks (Schuler, S. R., et al. 1995).

In the 1980s, government started giving limited attention to integrating men into FPP. During this period, the primary purpose of integrating men into FPP was to increase the number of male family planning method acceptors and also to promote husband's support for their wife's contraception. Family Planning Inspectors (FPIs), the supervisors for the female Family Welfare Assistants, were recruited to work at the Union Health and Family Welfare Centers. In addition to supervising the Family Welfare Assistants, FPIs were responsible for promoting men's

participation in family planning (Perry, H. B., 2000). The main reason to involve men in family planning was to increase the number of the users of male contraceptives. Such narrowing down of the concept of men's involvement in family planning reduced men's role to that of family planning method acceptors.

After 1994, the fifth five year plan of Bangladesh (1997-2002) committed to achieving the objectives of the Programme of Actions of the International Conference on Population and Development (ICPD).The move towards a wider RHP from its formerly narrow design necessitated changes in the FPP. Initially, this shift was marked, in many countries, only on paper by replacing the term "family planning" with "reproductive health programme." Over time broader strategies were conceived to meet the needs of the RHP.A study on post -Cairo reproductive health policies and programmes in eight countries--Bangladesh, Ghana, India, Jamaica, Jordan, Nepal, Peru, Senegal--conducted in 1997, reported that Bangladesh had made significant progress in setting priorities, financing and implementing reproductive health interventions (Viadro, C., 2000). Nevertheless, these policies and strategies, in many ways, were lacking in their ability to respond to the increasing needs of the RHP in Bangladesh. In general, family planning still remains a priority, followed by maternal and child health and HIV/AIDS prevention and treatment. Post abortion care and programmes for adolescents are receiving increasing emphasis. However, the reproductive rights aspects of the ICPD Programme of Action have received significantly less attention than the health aspects (Viadro, C., 2000).

The shift towards a more comprehensive RHP in Bangladesh was marked by the introduction of new services under the Essential Service Package (ESP): child health care, reproductive health care, communicable disease control, behaviour change communication, and limited curative care (Fifth Five Year Plan 1997-2002). In the wake of the important shift from FPP to RHP, strategies for male involvement broadened slightly. Male involvement initiatives were acted upon in order to get men involved in the prevention of STIs (sexually transmitted infections) and HIV/AIDS. Critical preventative information was providedon how to engage in safe sex. Some facilities were made available for limited treatment of STIs.

Making men responsible for prevention of STIs and HIV/AIDS has a long way to go. Condom use continues to be severely underutilized. Even though the contraceptive prevalence rate in Bangladesh increased from 8 percent in 1975 to 58 percent in 2004, use of condom increased from 0.7 percent to only 4.2 percent in 2004 (NIPORT, 2004). Research has found that, even though non-marital and commercial sex are not high in Bangladesh in comparison to the international standard, most of these types of sexual encounters are characterized by unprotected sex (Caldwell and Pieris,1999). It has been reported that only 12 percent of the subjects used condoms during sex with their non-marital/casual sexual partners (Caldwell and Pieris, 1999). Similarly, a situation analysis of sexual behaviour in Dhaka City showed that premarital and extramarital sex, as well as sex with commercial sex workers (CSWs), is prevalent (Chowdhury, S. N. M., et al., 1997). Importantly, most men who have sex with CSWs do not use condoms. Knowledge about HIV/AIDS continues to be poor among both men and women in Bangladesh. Among ever married women, 40 percent know nothing about HIV/AIDS. And among those who know about HIV/AIDS, 19.1 percent do not know any of the correct ways to avoid it (NIPORT, 2004). Only 21.9 percent of ever married women know use of condom as a way to avoid HIV/AIDS and 18.1 percent of ever married women know that limiting the number of sexual partners is one method of avoiding HIV/AIDS (NIPORT, 2004). Among men, 18.1 percent know nothing about HIV/AIDS (NIPORT, 2004). Of those who know about HIV/AIDS, only 40 percent know that condom use is an effective method of avoiding the disease. Only9.6 percent know that limiting the number of sexual partners is way to avoid HIV/AIDS (NIPORT, 2004). Unfortunately, even though the government has taken small steps to educate men with regard to safe sex practices, such efforts have only had limited success, even in terms of awareness building.

Missing Areas Needing Immediate Attention

Maternal mortality and antenatal, post natal and delivery care

At 322 per 100,000 live births, maternal mortality continues to be significantly high (NIPORT, 2003). The leading causes of maternal mortality are related to pregnancy and childbirth. Bangladesh has quitean extensive maternal and child health services network from grassroots to higher levels. Female field workers visit pregnant women at their homes and motivate them to visit paramedics for antenatal check-ups at Community Clinics or at the Union level Health and Family Welfare Centre (Khanum, P.A., et al, 2002). Even then, health care seeking remains very poor during pregnancy, childbirth and after childbirth. Almost half of all mothers do not receive any antenatal care during their pregnancy (NIPORT, 2004). There exists a large urban rural difference in antenatal coverage. Among urban women, 71 percent receive antenatal care from a medically trained person in comparison to 43 percent of rural women (NIPORT, 2004). Deliveries at the health centre are done under medical supervision and reduce the risk of complications and infections that can lead to death or serious illness of the mother as well as the new born. In Bangladesh, however, the use of health centres for delivery is not common. Almost91 percent of the del iveries take place at home (NIPORT, 2004). Unless this behaviour can be altered, maternal mortality is likely to remain very high.

Maternal and child health (MCH) was integrated with FPP as early as 1975 (MOHFW, Haider, 1995; MOHFW, Khuda, B., 1992). However, since the inception of the MCH programme, men have been totally missing.

Abortion

Abortion related maternal deaths are significantly high. Unsafe abortion causes approximately 8000 maternal death every year in Bangladesh (Akhter, H. H., et al., 1996). Deaths and disability resulting from induced abortion can be averted in a number of ways. Decline in unwanted pregnancies and decline in the proportion of unwanted pregnancies that end in induced abortion can substantially reduce the deaths and disabilities resulting from induced abortion. Further, induced abortion can be made safer and complications of induced abortions can be treated more successfully (Maine, D., et al., 1998). Men's participation is crucial in order to improve this situation. Regrettably, Bangladesh's FPP has never considered the role of men in averting abortion related maternal deaths.

Infertility

Childlessness causes serious vulnerability for women in Bangladesh. Nevertheless, infertility has never been considered an issue of reproductive health. It is generally assumed that women are always the cause of infertility (Ghafur, T., 2003). Most people are unaware that male partners can be a cause of infertility. Consequently, women bear all the burdens of infertility, including hazardous treatments, stigma, maltreatment, violence, abandonment and divorce (Ghafur, T., 2003). Poor people have very limited access to specialized treatments for infertility. Therefore, poor women often seek help from "quacks" who expose them to hazardous, indigenous treatments. RHPs should place more emphasis on developing strategies that will enable people to understand the reasons underpinning infertility. Men should be made active stakeholders. Men's active participation is crucial in order to determine preventable causes of infertility. Men should be motivated to get evaluated along with their wives for infertility.

Autonomy of decision and movement

Many women do not have the freedom to make important decisions regarding their reproductive health. And, in many cases, their movements are restricted by men, making it difficult, if not impossible, for them to visit clinics in order to get information and or help with reproductive matters. This is particularly true for adolescent mothers. The following tables depict women's control over decisions that affect their life (table 1) and freedom of movement (table 2).

Women's autonomy is further curtailed to the extent that they are subject to being beaten by their male partners if they violate the norm of seeking husband's permission before going out of the home. Almost half (49%) of currently married men believe that they are justified in hitting or

Table 1: Percent of Currently Married Women Participating in Decision Making

Residence	Alone or jointly have final say in:				
	Own health care	Child health care	Visits to family or relatives	Large household purchase	Daily household purchase
Rural Urban	44 53	53 62	53 65	53 64	53 64

Source: Bangladesh Demographic Health Survey, 2004.

Table 2: Percent of women who say they go or can go outside the village or town, or to a hospital or health centre

Residence	Goes or can go alone outside village	Goes or can go to a health center or hospital	Goes or can go to both places
Rural Urban	29 38	28 43	14 25

Source: Bangladesh Demographic Health Survey, 2004.

beating their wife if she goes outside of the home area without telling her husband (NIPORT 2004). Therefore, it is evident that targeting women alone will not improve this situation.

Violence against women

Gender-specific violence is one of the major reproductive health concerns of women in Bangladesh. This is an area that the RHP must focus on. Such violence originates from family as well as from society at large (Baden, S., et al. 1994). Violence against women within the household is primarily committed by husbands and in laws, and such violence ranges from battering to murder. Battering of women within the household by husbands and in laws is very common in Bangladesh. According to Baden (1994), there are many reasons for battering: failure to meet the demands of the husband (e.g., not preparing food on time), not taking care of children, insufficient dowry, etc. Men also beat their wives out of frustration, poverty, and powerlessness. Very few incidences of family violence are actually reported to the police. Violence against women from "society" can be even worse, and may include acid throwing, murder, rape, abduction and trafficking (Baden, S., et al. 1994). The RHP of Bangladesh has not duly integrated violence as an issue of reproductive health. In fact, RHP does not go beyond giving treatment for

injuries resulting from violence. Violence against women, having far reaching implications for reproductive health, needs to be adequately addressed by the reproductive health policy and programme of the government. With regard to violence against women,men are obviously key role players. RHPs must, therefore, educate both men and society at large in a manner that will reduce violence against women in the future.

It is clear that RHPs in Bangladesh have not paid sufficient attention to involving men in core areas of reproductive health. This omission is a source of many female and male health problems. This is problematic because men make most of the critical decisions during pregnancy, delivery, and after child birth. Studies have found that husbands are the primary decision makers with regard to their wives use of obstetric care services (Khanum P. A., 2000; Ahmed S., et. al. 1997). Such decisions impact the health of women and children (Khanum, P.A., et al, 2002). Therefore, a husband's decision, if timely and correct, can save the life of his wife and/or children. In the absence of full integration of men into the RHPs of Bangladesh, it is likely that no real positive change will occur in the above-mentioned problem areas, and women and children will continue to suffer as a consequence. Relatedly, if males are not successfully and fully integrated into Bangladesh's RHP, Bangladesh will almost certainly not be able to meet the Millennium Development Goals related to reproduction and sexual health.

Involving Men in Bangladesh's RHP: Prospects and Possibilities

Men in Bangladesh already have a positive attitude towards contraception. Men are not perceived as an obstacle by the wives for their contraception. Moreover, there also exists parity between the desired family size between husbands and wives regardless of residence, education or age (NIPORT, 2004). Hence, men in Bangladesh are to some extent playing a positive role as far as it relates to contraception and reduction of fertility. Men's role can be made further positive and all encompassing.

Studies conducted by ICDDR have shown that integrating men into RHPs has a positive impact on the health of both women and children (Khanum, P.A., et al, 2002). It has been found that the depth and quality of knowledge husbands have about obstetric complications is positively associated with their wife's use of obstetric care services (Khanum, P.A., et al, 2002). Inadequate knowledge about emergency obstetric problems, facilities, and financial costs have been found to be the major reasons for not seeking emergency obstetric care (Piet-Pelon, N. J., et al. 1999). Under these circumstances, men should be an integral part of all components of safe motherhood. Husbands do not, however, participate or share the responsibility for ensuring their wives health during pregnancy and after child birth largely because they are made to believe that it is not their responsibility. In other words, when it comes to matters related to sexual health, it the sole responsibility of the woman. This is the prevailing attitude in Bangladesh among men.

RHPs must be structured in a manner that will make husbands an integral part of the entire process of safe motherhood (and childhood). Strategies should be taken to make husbands keenly aware of the necessities of safe motherhood and should detail their roles and responsibilities. Special care should be taken to ensure that the flow of information from change advocates to men is clear about the special role and responsibilities of men with regard to safe motherhood. Such messages should be gender sensitive and should in no way reinforce destructive stereotypes. Husbands should be approached through public information and education campaigns. They should also have more private interaction with health care providers. In the service delivery points, providers should promote husband's participation in the whole process. Couple counseling approaches should also be encouraged. RHPs for adolescents should be stepped up and should emphasize mutually supportive male-female relationships during pregnancy and child birth along with male participation in caring for children. These programs should also strongly emphasize that violence against women is not acceptable under any condition.

Recent research has shown that men can be successfully integrated with the existing RHP in Bangladesh. The National Institute of Population Research and Training (NIPORT), the Directorate of Family Planning, and the FRONTIERS Programme of the Population Council recently collaborated on research investigating the feasibility of introducing reproductive health services for men in Health and Family Welfare Centres (HFWCs). The intervention study illustrated that reproductive health services for men can be effectively integrated within the existing women focused service centres without compromising services to female clients (Hossain, S. M. I. et al. 2004). The study found that men and women were eager to seek RTI/STI services within the same centre. Integration of services for men in HFWCs increased the rate of utilization by both men and women.

Conclusion

Involving men in the reproductive health programme should receive priority in its own right. Men have their own reproductive health problems. Men's reproductive health concerns include family planning, sexually transmitted diseases prevention and treatment, sexuality and sexual dysfunction, infertility, urologic conditions, among others. They have the right, as do women, to have access to all of the currently available reproductive health services. On the other hand, reproductive health has a built -in shared approach. One partner's decision-making and behaviour affects the reproductive health of the other partner. Reproductive function is a joint function. Therefore, any approach in reproductive health that ignores men or women will be incomplete and ineffective. RHP must, therefore, focus on both men and women. The need to involve men in RHP resulted from the realization that men's exclusion was generating gender inequality and inequity in reproductive health. Gender equality is concerned with formal provision of reproductive health service delivery for men and women, and with equal opportunity laws and policies and reproductive health service delivery systems. Therefore, men's integration from this perspective means making reproductive health information and services available to them. The gender equity approach in reproductive health demands more than just formal provisioning of reproductive health services and information for men and women. It is also concerned with taking affirmative action to remove existing inequalities in terms of poor health status and poor health seeking practices of men or women. It demands that actions be taken to ensure the equal status of men and women in terms of reproductive health decision making and health care seeking.

The idea of male involvement is to integrate men into the RHP so that they can have access to reproductive health services and play the desired role to address existing gender inequalities and inequities in matters relating to reproductive health. Involving men means making them a service recipient of RHP. It also means making them participate in their partner's reproductive health matters, and making them responsible for their behaviour, action or inaction. Programmes should provide services for men and give them information about their role in ensuring their partner's reproductive health. This will allow them to better focus on their larger role. Men's involvement may take the form of active participation in many forms and ways (e.g., men as condom users to avert unwanted pregnancy or ensure safer sex; men as companions, attending reproductive health centers with their wives; men as active promoters of their wives role in decision making, among other things). Men can also get involved by supporting the actions and decisions of individuals, groups, NGOs, and institutions that are promoting the reproductive health of both men and women.

Since its inception, the RHP in Bangladesh has been focused on women to the near exclusion of men. Some disjointed efforts have been taken to involve men, but approaches have been incoherent. During the 70s and 80s, male involvement initiatives under the FPP were directed at increasing users of male methods of contraceptives. Men were reduced to playing the role of contraceptive acceptor. The early programme failed to appreciate the wider role of men in family planning and safe motherhood. Under the present RHP of Bangladesh, male involvement

initiatives have been directed towards promoting safe sex, primarily in order to prevent the spread of STIs and HIV/AIDS. Male involvement initiatives have not embraced a systematic approach. They have never been fully focused on attaining gender equality and gender equity. Existing and future programmes should follow an institutional approach in attempting to fully engage men in all areas of reproductive health. The objective of involving men in reproductive health should be to improve the quality of life for men, women and children via the removal of gender inequalities and inequities. Success demands that men be transformed into "active stakeholders." On issue of male involvement in reproductive health, a serious concern is weather encouraging men's participation will result in perpetuating existing gender inequalities, particularly with regard to communication and sexual decision making. Therefore, programmes will have to be carefully designed so that they do not reinforce existing and destructive gender imbalances and male-female stereotypes. In addition, new programs designed to involve men as partners in reproductive health must not result in a reduction in funding of programs designed to improve women's health.

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