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Male Involvement in Family Planning in Bangladesh: Factors Constraining Low Use and the Potential for Augmenting the CPR

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1. Introduction

The concept of male involvement in family planning is broad in nature. The programme of action adopted by the International Conference on Population and Development (ICPD) held in Cairo 1994 notes (special efforts should be made to emphasise men's shared responsibility and promote their active involvement in responsible parenthood, sexual and reproductive behaviour, including family planning; pre-natal, maternal and child health; prevention of Sexually Transmitted Diseases (STDs); and prevention of unwanted and high-risk pregnancies." Use of male methods is one important aspect of male involvement in family planning.

Historically, the traditional method withdrawal (coitus interruptus) has been used as a contraceptive method since biblical time (PA1, 1991)[1]. And use of condom dates back to 400 years (Ross and Frankenberg, 1993). Despite the pioneering role-played by the age-old male methods in the evolution of family planning, the present contribution of male methods (traditional and modern) to the total Contraceptive Prevalence Rate (CPR) is strikingly low. Worldwide, one-third of the eligible couples using family planning relies on methods (vasectomy, condom, withdrawal and periodic abstinence) which require full male co-operation. In the developing countries during the period 1970s and early 1980s, about one-fourth of the contraceptors relied on male methods (Population Reports 1986). In the past decade (1990s), although there has been overall increase in the level of contraceptive prevalence, low use of male methods is likely to remain static in most of the developing countries.

Even in developing countries like China, Thailand and Indonesia with high level of contraceptive prevalence, the use rate of male methods is very low[2]. From a historical perspective, in western countries and Japan, male methods have played a greater role in fertility control than have female methods (United Nations, 1996). The traditional method withdrawal-was widely used in past centuries in Europe, contributing to the demographic transition (Potts, M 1985)[3]. The family planning needs of men, both as a group and individuals have been essentially ignored by most programmes for two reasons; first modern contraceptives have focused mainly on women. Since 1950s and 1960s when most family planning programmes started in Asia, injectables and implants have been developed and oral pill and IUDs improved. The second reason is that efforts have been directed at improving the health of women and increasing survival rates for men. Over the past decade

[1] Coitus interruptus – or withdrawal, as it is commonly known – may be the oldest means of preventing pregnancy. Islamic legal writings dating back several centuries sanctioned its use (Musallam, 1983).

[2] With CPR of 72 per cent in China (1988), 68 per cent in Thailand (1987) and 50 per cent in Indonesia (1991), the respective share of male methods in each country was 11 per cent, 9 per cent and 3.2 per cent (population reports 1992, 10p and IDHS 1991).

[3] In 1960 US survey 50 per cent of married women age 18-44 reported that at some time they and their partners had relied on withdrawal. In a 1959-60 survey in Great Britain 49 per cent of the married men and women had ever used condom and 44 per cent had ever used withdrawal. (population reports 1986, 895p).

the findings of the surveys suggest that men and women do not necessarily have similar fertility attitudes and goals (Ezech 1993 and Bankole 1995). Moreover, the scope of fertility and family planning research has expanded to include such broader reproductive health issues as Sexually Transmitted Diseases (STDs) on which data from both men and women are needed (Becker 1996). The effect of men's attitudes and behaviour on women's health is perhaps most obvious with regard to the pandemic of Acquired Immune Deficiency Syndrome (AIDS) and other STDs. Efforts to promote family planning in developing countries have, therefore, been criticized for their exclusion of men (Akinrinola and Susheela 1998). It is contended that programmes can serve family needs better by addressing men as well as women (Carlos 1984, Gulhati 1986 and Wellings, K 1984). Men need to share the responsibility of disease prevention (i.e., HIV/AIDS) as well as the risks and benefits of contraception (Wegner et.al. 1998).

It, therefore, implies that failure to involve men in family planning can have serious implications. In Bangladesh, the situation of male participation in family planning presents a dismal picture. That is, with over half of the eligible couples (54 per cent) currently practicing contraception, only 14 per cent use the male methods. This low level use of male methods use indicates that further increases in the CPR in the country can only be achieved by promotion of active male involvement in family planning.

Moreover, the potential threat of HIV/AIDS in Bangladesh underscores the need to enhance the marital use of condom – a male contraceptive method. But the current rate of marital condom use in Bangladesh is very low (4 per cent). Use of condom serves as a protector of the infection of STDs/HIV and AIDS.

Since 1993-94 Total Fertility Rate (TFR) in Bangladesh has been hovering around 3.3. This issue raises concern among the policy makers regarding the impact of increase in the level of CPR on TFR in the absence of socio-economic development (CPD Task Force Report 2001). It is important to note that there is a little scope to make the CPR more effective, depending only on the female methods of contraception (now with predominant use of oral pill) to the neglect of use of male methods. Therefore, male participation in family planning has become all the more imperative in Bangladesh and this should be a major policy objective of the government. But greater efforts directed at increasing male methods have been stressed a little in the new population policy (revised), 2000.

1.1 Objectives of the Paper

The objectives of the paper are as follows:

1. to underline the factors constraining low use of male contraceptive methods in the country.
2. to explore the men's potentially positive role to augment the Contraceptive Prevalence Rate (CPR) in Bangladesh.

1.2 Sources of Data and Methodological Aspects

The present report '*Male Involvement in Family Planning in Bangladesh: Factors Constraining Low Use and the Potential for Augmenting the CPR'* is based on secondary information that are available from various sources. The study is based on data of Bangladesh Demographic and Health Survey (BDHS), Bangladesh Fertility Survey and

Contraceptive Prevalence Survey etc. Using the secondary data as mentioned above, would mainly focus on trend in current use of family planning methods in Bangladesh and the proportional share of male methods to the overall contraceptive use rate.

An analysis of some other important aspects of male participation in contraceptive use (i.e., user characteristics, regional variation in method use, discrepancy in reported use of male methods etc.) are also based on secondary data. Over and above, core issues to the present study (i.e., problems and prospects of male method use in Bangladesh) are highlighted using information from various sources. This has also been further supplemented by field observation.

1.3 Organisation of the Paper

The paper is organised as follows:
(1) Introduction (2) Literature Review (3) Importance of Male Participation in Family Planning (4) Level and Trend of Contraceptive Use in Bangladesh (5) Current Status of Male Participation in Family Planning in Bangladesh (6) Constraints of Male Participation in Bangladesh (7) Prospects of Male Participation in Bangladesh and (8) Conclusions and Policy Recommendations.

2. Literature Review

There is a limited number of studies which have attempted to reveal the various aspects of the broad theme on 'Male participation in family planning in Bangladesh'. This review focuses on the findings of some recent studies given below.

Men and Family Planning in Bangladesh
(Final Report)
Author: Debbie Donahoe, 1996
This report has been prepared on the basis of research findings of survey data and other literature covering a variety of topics such as, male fertility preferences, male knowledge, attitude and practice (KAP), opinion about male methods of contraception, family planning (FP) decision-making and recent efforts to involve Bangladeshi men in FP programmes. This report has largely drawn on the findings from the Bangladesh Demographic and Health Survey (BDHS), 1993-94.

Men's desired family size in Bangladesh is small, only one third of the respondents wanted more than two children. and knowledge of at least one modern method of family planning is virtually universal (BDHS 1993-94). The same survey revealed that men's attitudes towards family planning (FP) are overwhelmingly favourable even in the country's most conservative division, Chittagong (combined with Sylhet). Religious opposition to FP among men seems to be less common than usually thought (Bernhart and Mosleh 1990, Mazumder, 1993). The use of vasectomy remains insignificant in Bangladesh. A considerable number of both men and women report unfavourable impressions due to perceived side-effects (Khan 1979, Mitra and Mitra 1990. Islam and Rahman 1993). The method's unpopularity is largely attributed to supply-side constraints i.e., the emphasis on other methods and deficiencies in the availability and quality of vasectomy services (Hasan et.al.. 1992, Ahmed et.al. 1992, Khuda, 1994). An increasing number of both men and

women have also negative impressions about the use of male method- condom. It is thought to be detrimental to one's health (Mitra 1990) and to be unreliable (Folmar,1992, Khan, 1993). With regard to information on spousal communication on contraceptive use, nearly 40 percent of female respondents in the DHS reported that the decision to first use a contraceptive method was reached jointly with their husbands. Some husbands are both significant sources of information about methods and supplies of methods for their wives (Davis et.al., 1978, Akther and Ahmed 1991).

Finally, it seems that not much efforts have been as of yet, undertaken in Bangladesh to involve men in family planning programmes.

Limitations:

1. Information on the use of traditional male methods of contraception (i.e., withdrawal and periodic abstinence) in Bangladesh is not provided in this report.
2. Little is mentioned about the status of male participation in the national family planning programme.

Male Involvement in Family Planning Programme: Bangladesh

Authors: Ubaidur Rob, Shirin M Khuda and A.Y. Chowdhury (1996)[4]

The objective of this paper is to examine the status of male involvement within the family planning (FP) programme in Bangladesh, in addition to constraints in the way of promotion of male methods.

In early 1950, FP activities were first initially initiated on voluntary basis, mainly concentrated in urban areas. Male sterilisation programme was introduced in 1965 and over one million vasectomies were performed during the period 1965-70.

In 1975, a separate directorate was established to gear up population activities in Bangladesh. Several steps were taken to co-ordinate FP activities in conjunction with health services. To reduce high maternal and infant deaths the programme changed its target audience and shifted its focus towards females by promoting female methods. To achieve greater female involvement, the programme was re-organized at the field level. Females were deployed in large numbers as front line field workers and male workers were with drawn. Moreover, introduction of minilap technique and availability of trained female paramedics encouraged females to accept clinical methods, particularly IUD and tubectomy (Haider and Kabir 1989). This resulted in reduction of male methods acceptance. To provide services the government established hundreds of family welfare centres (FWC) in rural areas and Thana Health Complex (THC) at the thana level.

The government introduced a system of compensation payment for sterilisation acceptors (i.e, male and female) in 1976. Significant increases in the number of acceptors were not observed until early eighties. However, the target system of the workers (i.e., two

[4] See, National Institute of Population Research and Training (NIPORT), GTZ, Population Council land AVSC International. 1996. Male Involvement in Family Planning: A Challenge for the National Programme Workshop. Final Report.

sterilisation and one IUD acceptor per month) introduced in 1983 was subsequently abandoned by the government in July 1987 (because of reported coercion by the workers).

The paper also gives a short description of special projects on family planning and NGO programmes in Bangladesh. During 1975-80, two projects, namely, Zero Population Growth (ZPG) Project and Social Marketing Project (SMP) were initiated. The ZPG project failed to produce desired results while SMP continued its operation. The World Bank funded Fourth Health and population project was introduced in Bangladesh in 1991. However, no major focus was given on greater male involvement in this project.

Limitations:
1. The article does not mention the major programmematic constraints in the way of promotion of male method use in Bangladesh.
2. The primary objective of the study (i.e., position of male involvement in the national family planning programme) has not been consistently discussed in the article.

Males as FP – MCH – RH Service Providers
Authors: M. Alauddin and AKM Rafiquz-zaman 1996.
In this paper, the authors present an analysis on performance and quality of male providers in family planning services, in Bangladesh specifically promoting male methods. Several measures are also suggested to increase the use of male methods in Bangladesh.

In the FP programme, there are more than seven thousand male field staff (FPI, MA. and Family Planning NGO staff). In the Health Directorate, there are almost six thousand physicians (with at least 60 per cent males), in addition to a large number of health assistants (14,381) at the grass root level. Moreover, a considerable number of male providers are also employed in the non-government organization (NGO) and private sector. According to a study (UNFPA-VH SS, 1989-90), nearly 60 per cent of total 51,599 workers in 169 NGOs were males. Several studies, however, reported gross under performance of the male field staff of the directorate of health and family planning (Rahman and Rahim 1984, Ahmed S 1994 and Ahmed et.al. 1996). All service sites do not have trained male physicians to offer male sterilisation services. Even in the face of declining performance in sterilisation (for example, less than 1000 vasectomy performed per month in 1995). There is evidence of significantly high performance because of strong programme action. (BRAC 1995).

The following measures, among others, are suggested for increased utilisation of male methods.

- Appropriate use of male field-workers in the government health and FP programme to provide men with FP services and prevent Sexually Transmitted Diseases (STDs).
- Involve the village practitioners to promote male methods.

The paper needs to state the reasons of low performance of the male field staff.

Highlights of Regional Male Involvement Family Planning Programmes
Authors: Nancy J. Piet – pelon and Ahmed-Al-Kabir, 1996.

In addition to other issues, the paper has also compared the status of Bangladesh with some other selected countries in Asia and the Middle East, with regard to current use of male methods during the period 1991 to 1995.

There is great variation across countries (i.e., India, Indonesia, Pakistan, the Philippines, Egypt and Turkey) in the use of contraceptive methods which require male participation. With a high level of CPR (62.6 per cent) in Turkey, withdrawal is the most popular method (26.2 per cent) and condom use is nearly 7 per cent of all current users (BDHS 1994). In the Philippines, with 40 per cent of the contracepting couples, withdrawal and periodic abstinence are each used by 7 per cent of current users (PNDS 1993). Indonesia has very low use of all male methods i.e., 3.2 per cent out of CPR 50 per cent (IDHS 1991). With CPR of about 41 per cent in India, participation of male methods to it is 9.8 per cent. Only the current use rate of vasectomy (3.4 per cent) exceeds the other male methods (NFHS 1992-93). Half of the total contraceptive use (i.e., 8.9 per cent) is shared by male methods in Pakistan, withdrawal being most dominant in use (4.2 per cent) and vasectomy acceptance is nil. In Egypt, share of male methods to over all level of contraceptive prevalence (47 per cent) is strikingly low (BDHS 1992). Among these countries, Bangladesh's position in terms of current use of male methods (11.4 per cent) is next to Turkey and the Philippines. The article does not specify why Turkey has the highest use rate of the traditional male method-withdrawal.

Role of Male as the User of Contraceptive Methods

Authors: Abu Jamil Faisel & Jahir Uddin Ahmed,1996.

The authors emphasise the role of male in the use of contraceptive methods. In a patriarchal society like Bangladesh, men as the husband in a couple's life have an important say in decision-making about family size and use of contraceptives. As the FP service delivery system is largely female-oriented, there are very limited opportunities for men to receive FP information from service providers. Vasectomy remained to be a popular method until 1984-85. Since then along with tubal ligations vasectomy acceptance started declining. In a study (Faisel, Landry and Mental 1995) in Bangladesh, it revealed that most of the vasectomy users and their spouses had decided to have a vasectomy during their last pregnancy.

Male respondents had first heard vasectomy, mainly from radio and health or family planning workers. The major reason mentioned by all the men for choosing vasectomy was its permanency.

Inter-spousal communication on reproductive issues is very minimum in Bangladesh (BDHS 1993-94). The measures suggested in the paper are mainly as follows:

1. Services and male contraceptives need to be well publicised, emphasising on benefits of use of male methods and Information, Education and Communication (IEC) activities have to be carried out.
2. The health and FP service delivery centres should counsel men on their reproductive responsibilities and use of contraceptive methods.
3. Service sites need to be set up within the reach of men to cater to their needs.

The article has mainly concentrated its discussion on the use of vasectomy -a permanent male method. But little is mentioned about the use of other male methods (i.e., condom, withdrawal and periodic abstinence).

Male Motivation for Promotion of Women's participation in Decision-Making – An Important Element of Family Planning Programme

Authors: Ahmed Al Sabir, Habibur Rahman and Nazrul Islam

In Bangladesh, decisions about family size and the use of contraceptives by wives and their continuation depend largely on the decisions of their husbands. A study (Hassan and Huq 1990) revealed that decisions about adoption of family planning are mainly taken by the males. Other two studies (Hassan and Huq 1990, Ahmed, et.al. 1990) showed that the males had the highest influence in deciding about the acceptance of sterilisation.

One of the pioneering studies showed that male involvement in contraception decision is seldom recognized in family planning (FP) programmes, even though men play a key role in the contraceptive decision-making process (Gulhati 1986). Another study (Johnson 1983) found that, 'an overwhelmingly majority of sterilisations, as a chosen method of the couples, were obtained by women. The studies show that both socio-economic and socio-cultural factors are responsible for less participation of women in decision-making. A conceptual frame work developed by Al-Sabir and Jon Simons (1994) depicts the women's decision-making process in rural Bangladesh.

In Bangladesh, male involvement in family planning can be described in three forms, such as (i) males as users of contraceptives (ii) males as supportive partner of contraceptive and (iii) males as service providers.

Comparative position of males as contraceptive user, supportive partner and service provider in Bangladesh is not analysed here.

The Influence of Husbands 0n Contraceptive Use by Bangladeshi Women

Author: Nashid Kamal, 2000

Using the data from the 1993-94 BDHS, the objective of the paper is to examine the role of husbands on a couple's use of contraception in Bangladesh. In all three categories of use of modern contraceptive methods (i.e., oral pill, IUD/injection and female sterilisation) considered in this study, husband's approval of family planning led to the increase of any method used by females. Other studies found that women in Bangladesh have a tendency to use contraception only when they perceive that their husbands do not object (Kamal and Sloggett 1993). In other countries, for example, in Sri Lanka, women who husbands disapproved of contraception had a four times higher risk of unwanted pregnancy compared with those who husbands approved (De Silva 1992).

One of the limitations of this study is - husbands' influence on contraceptive use was investigated on the basis of only one variable (i.e., husband's opinion of family planning as perceived by the wife).

It appears from the above reviews that there exists gap to identify the factors constraining or facilitating greater male participation in family planning in Bangladesh.

3. Importance of Male Participation in Family Planning

Equity in gender relations and responsible sexual behavior highly stresses the need for men's active involvement in family planning. The interest in increasing active male participation in fertility regulation is two-fold: (1) to balance reproductive health care more evenly between men and women and (2) to increase the overall level of active users of fertility regulation (Martinez Manautou et.al. 1991). Donahue (1995) said male involvement in family planning generally signifies two distinct, yet-inter related, programmatic goals of encouraging the use of male contraceptive methods and expanding men's involvement in family planning decision-making process. The health of both men and women will improve, if men play a greater role in birth control. Male practice gives a balanced situation. Both from the perspective of birth prevention or reproductive health increased participation in family planning by males is, therefore, an essential step for augmenting the Contraceptive Prevalence Rate.

The most important reason that emerges to promote male participation in family planning is that of fostering a better relationship between men and women through the practice of family planning as a joint and equal responsibility. Moreover, with increasing awareness and concern about the role men play in the transmission of Sexually Transmitted Diseases (STDs) and HIV/AIDS, marginalizing men in family planning and reproductive health services is not, therefore, proper. It does not adhere to the principle of equity in gender in service dispensation.

According little importance to men's needs largely increases their health risks as well as those of their partners. In recent years, globally increase in the prevalence of STDs/ HIV/ AIDS has drawn attention to reproductive health needs of men (ICPD declaration, 1994). This has further added importance to use of the male method i.e., condom. Increased reliance on condoms can also help curb the spread of the STDs.[5] This, in turn, prevents the infection of the deadly diseases (HIV/AIDS). On medical ground, condom promotion has now gone beyond family planning. Men need to share the responsibility disease prevention (HIV/AIDS) as well as the risks and benefits of contraception (Wegner et.al. 1998). The need to increase men's participation and sharing of responsibility was also a recommendation of the 1994 International Conference on Population and Development – ICPD (United Nations 1995).

3.1 Family Planning Needs of Men in Bangladesh

Men constitute one-half of the population in Bangladesh but they are often forgotten sexual partners in family planning. Despite the fact that men play a vital role in all spheres of life including decisions about family size and practicing contraception by wives, they are highly disproportionately represented in family planning. This is because the Contraceptive

[5] Sexually Transmitted Diseases (STDs) multiply the transmissibility of human immunodeficiency virus (HIV), the acquired immunodeficiency syndrome (AIDS) virus, and as much as nine folds (population reports 1993).

Prevalence Rate in Bangladesh is overwhelmingly dominated by female methods (i.e., 39.6 per cent out of CPR 53.8 per cent). Men share a low proportion of the total CPR.

Despite the appreciable increase in the level of contraceptive prevalence in Bangladesh, the method-mix of current users continues to transform into an ineffective pattern with an insignificant proportion of use of clinical methods (Table –1). This suggests that there is a limit to raise the current contraceptive use rate in a developing country like us, depending on the female methods (oral pill, in particular) only. In the absence of effective and desirable level of male involvement, it is almost impossible for the family planning programme to reach its complete success in the near feature. The male methods (i.e., condom and vasectomy) are most cost-effective and any one can easily practice withdrawal-the traditional method of contraception. Current low level of male contraception in Bangladesh, therefore, indicates the urgency to actively involve men in family planning to enhance contraceptive prevalence to its desired level. Moreover, men's participation in family planning will create interest about their reproductive health needs (i.e, awareness about the risks of STDs/HIV and AIDS). Involvement of men in family planning in Bangladesh is intended not only to increase the over all use of contraceptives but it is also essential on social and medical grounds.

Social Grounds:
The most important role of men in family planning is that it ensures shared responsibility and promotes his active involvement in responsible parenthood and sexual and reproductive behavior of both husbands and wives. As supportive partner in decision-making, couples can either make a joint decision or a man can allow his partner to make a decision, which suits her. Supportive partners educate themselves about methods (both male and female ones) in order to help make informed decisions.

Medical Grounds:
Although Bangladesh continues to be a low prevalence area with regard to HIV/AIDS, many of the determinants for an explosive outburst exist in the country that indicate the country's vulnerability. According to an official figure available until 1996, Bangladesh has about 2.3 million cases of Sexually Transmitted Diseases (STDs) (GOB 1998). In most serious stages, STDs take the form of HIV-causing AIDS. STDs, therefore, pose a potential major public health problem in the country. The growing concern of STDs has been intensified with increasing mobility of men in search of work.

The possibility of STDs among the overseas Bangladeshi migrants, the unmarried young in particular, can hardly be ignored. Though their exact numbers can not be ascertained due to lack of detection, it can be believed that the potential of STDs and HIV/AIDS among them is not insignificant. This important health aspect of the overseas Bangladeshi migrants has drawn little attention of the government of Bangladesh. The most effective technology yet developed against the spread of HIV/AIDS is still condom. With advent of HIV/AIDS and increasing STDs, the promotion of condom use as a prevention of infection is most essential in Bangladesh. The current low rate of marital condom use in the country, however, indicates that there has been little promotion of condoms expressly to prevent STDs which in turn checks the onslaught of HIV/AIDS. Evidence shows that promotion of

condoms for AIDS and STD prevention does not affect their use as a family planning method and in fact, may increase it. Portraying condom use as a community norm or a part of every day life can help to improve the image of condoms.

4. Level and Trend of Contraceptive Use in Bangladesh

4.1 Current Level of Contraceptive Use

Table –1 shows that overall nearly 54 per cent of the currently married women (CMW) are currently practicing contraception in Bangladesh – 43.4 per cent modern methods and 10.3 per cent traditional methods. In recent years (1997-2000), contraceptive use has increased by 5 per cent from 49 per cent to about 54 per cent of the currently married women at their reproductive ages (MWRA) i.e., 15-49., averaging an increase of 2.5 per cent a year. During the same period, while modern method use increased only 5 per cent, use of traditional methods rose by 34 per cent. [6] In the year 1999- 2000, the widely used method is oral contraceptive pill (23 per cent), accounting for 43.2 per cent of the total CPR (i.e., 53 per cent), other commonly used methods are female sterilisation and injectables (7 per cent each). Periodic abstinence (5 per cent) and condoms and withdrawal (4 per cent each) (Table – 1).

Over the last two decades (1975-2000) there had been a steady increase in the current level of contraceptive prevalence in Bangladesh. In 1975, only 8 per cent of the currently married women reported using family planning methods, the proportion rose to 54 per cent in 1999-2000.

In Bangladesh the rather significant increase in the current level of contraceptive prevalence since 1975 is highly dominated by modern contraceptives.

4.2 Trends in Specific Method Use

In Bangladesh, the method-mix of users has changed overtime. The major change since late 1980s has been a large increase in the use of oral pill (i.e., from 9.6 per cent in 1989 to 23 per cent in 1999/2000). Since 1994, use of the methods such as oral pill, injectables and condom has increased appreciably. Use of the permanent method (i.e., sterilisation) has rather declined considerably and of Intra-uterine Device (IUD) has stagnated. For

[6] Use of the word 'traditional' implies an expectation that users of methods which come under its ambit represent a group of people who want to limit their families or space their children apart but who for one reason or another do not have access to 'modern methods' or perhaps even that they are bound by cultural values to shun modern methods (Gray, Chowdhury, Caldwell and Al-Sabir 1997). This expectation has been modified by studies in another South Asian Country, Sri Lanka (Caldwell et.al. 1987 De Graff and De Silva 1991), where it was found that far from being used because no modern methods were available or accessible, methods such as periodic abstinence and withdrawal were the family planning methods of choice for many couples. A traditional method in family planning literature refers to any type of contraception that was 'practiced prior to the availability of the pill and IUD in the 1960s [or] that do not depend on supplies or material objects (Caldwell et.al. ibid.).

example, during the recent period (1993/94 to 1999/2000) level of oral pill prevalence has increased steadily from 17.4 per cent to 23 per cent and that of injectables from 4.5 per cent to 7.2 per cent and condom from 3 per cent to 4.3. The use rate of sterilisation has, on the other hand, decreased by about 2 per cent (i.e., from 9.2 per cent to 7.2 per cent). Thus, it reveals that most of the increase in the level of contraceptive prevalence (19.3 per cent) during the said period has been contributed by these short-term methods. User effectiveness of the methods pill, condom and injectables is, however, low. [7]

Despite the fact of appreciable increase in the method use, the method-mix of current users continues to transform into an ineffective pattern with a low proportion of clinical method use (i.e., male sterilisation, female sterilisation, IUD).

5. Current Status of Male Participation in Family Planning in Bangladesh

5.1 Knowledge and Attitudes of Males about Family Planning

Knowledge of family planning (FP) methods is high among Bangladeshi couples. According to the 1999-2000 BDHS, knowledge of any family planning method among the currently married men is universal. A high proportion of them (90 per cent or more) know about oral pill, condom, injectable and female sterilisation. Comparatively, they are less likely to know about male sterilisation (87 per cent). Among the traditional male methods of contraception i.e., periodic abstinence and withdrawal more men (74 per cent) than women (67 per cent) reported knowing of the former method and a lesser proportion reported knowing of the latter method (47 per cent versus 57 per cent).

Wives are generally more likely to know female methods than their husbands. Almost all of the currently married women know about pill, IUD, injectable and female sterilisation. Knowledge of at least one method (a modern method, in particular) is virtually universal among both women in the age group 10-49 and men in 15-59 in both urban and rural areas, in all divisions and irrespective of any category of education level.

Effective use of contraceptive methods is facilitated when both husbands and wives have positive attitude towards contraception. In 1999-2000, an overwhelmingly majority of the currently married women (82 per cent) reported that they along with their husbands approved family planning, only 5 per cent of women reported both they and their husbands disapproved.

The likelihood that a woman will report that both she and her husband approve of family planning is highest in the age groups 10-24 and 25-29. By location of areas, level of approval differs a little between urban and rural areas (i.e., 87 per cent and 80 per cent respectively). Approval by both husband and wife are higher in the Khulna and Rajshahi divisions (86 per cent in each) and lowest in the Sylhet division (60 per cent). Women with no education are also more likely to say that their husband disapproves or that they know little about their spouse's view.

[7] Nearly half of the users in Bangladesh discontinue use of contraceptives within 12months of starting use. Discontinuation rates vary significantly by method (i.e., condom 67 per cent, injectable 50 per cent, the pill 47 per cent and IUD 34 per cent. among the traditional methods, the rate for withdrawal (51 per cent) is higher than that periodic abstinence (43 per cent). Side effects of the method or other health reasons are by the most commonly reported reasons for discontinuing the pill, IUD and injection. There has been little change in discontinuation rates since 1996-97.

5.2 Level and Trend of Male Method Use in Bangladesh

Current level of male method prevalence

Table-2 shows that over half (54 per cent) of the currently married women of reproductive ages are using family planning methods because only 14.2 per cent rely on male methods.[8] It demonstrates that the share of male methods to the total Contraceptive Prevalence Rate (CPR) is very low (i.e., 26.4 per cent). The relative share of the specific male methods is condom; vasectomy, periodic abstinence and withdrawal are 4.3 per cent, 0.5 per cent, 5.4 per cent and 4 per cent respectively. In fact the traditional male methods are more pronounced in use compared to the modern male methods, accounting for about two-thirds of all male methods.

5.3 Trends in the Level of Male Methods Prevalence

Over the last two decades, the trends in the proportional share of male methods to the CPR can be seen from the table-2. From strikingly low use rate of male methods (2.6 per cent) in 1975, it increased steadily to 6.4 per cent in 1983 and 8 per cent in 1985. Between 1984 and 1989, increases in use were least pronounced. Again, from early 1990s a continuing rise in the use of male methods is perceptible (i.e., 10.4 per cent in 1991, 11.4 per cent in 1994, 11.9 per cent in 1996 and 14.2 per cent in 2000).

In most recent years, (Table-1) the increase in the use of the traditional method (i.e., withdrawal) was more perceptible (i.e., from 1.9 per cent in 1997 to 4 per cent in 1999/2000 –two-fold rise). On the other hand, the increase in condom use was relatively less pronounced (i.e., 10 per cent). Of the other two male methods, while practice of periodic abstinence increased a little, vasectomy declined further to a negligible figure (one-half percent) during the same period.

Over the years, although a continuing increase in the use rate of male methods is noticed, their relative shares to the total CPR have not shown a consistent and upward trend in use. For example, during the period, 1991-2000 it (Table 3) shows that the relative participation rate of male methods to the total CPR has either diminished or remained almost static as before (i.e., 26 per cent in 1991, 24.5 per cent in 1993/94, 24.2 per cent in 1996/97 and 26.4 per cent in 1999-2000).

5.4 Exposure to Family Planning Messages

Communication of information and education on family planning (FP) to the currently married women and men is an important step to motivate them to practice contraception. According to the data provided by the 1996-97 BDHS, nearly 70 per cent of men and a little over 40 per cent of women reported that they had heard or seen a FP message in one or four of the mass media (i.e., radio, television, bill board and newspaper/magazine). Men were much more likely than women to receive FP messages through any of the mass media. Data also showed that 58 per cent of men had heard a FP message on the radio, while 46 per cent had seen a message on television. Even bill boards and news

[8] Since 1996-97, information on the current use of contraceptive methods by the male respondents have been included in the DHSs. Reporting of the differential use rate of the method by men have been discussed in the succeeding pages.

papers/magazines are important means of exposure to men, with one-third having received FP messages from the former and one-fifth from the latter.

Generally, exposure to messages on FP decreases with age among both men and women. Urban respondents (male and female) are more likely to have been exposed to a media message than their rural counterparts. For example, only 39 per cent of rural women heard a message, compared with 67 per cent of urban women. The corresponding figures for men are 86 per cent and 66 per cent respectively. Higher urban than rural exposure is true for all four types of media. Differences in media exposure by division are not large (65 per cent to 76 per cent) except for Sylhet (48 per cent) where men have significantly less exposure to mass media messages on family planning. Exposure to the FP message through the mass media differs consider-ably by level of education. That is, 89 per cent of men with a higher secondary education had heard a FP message as against 54 per cent of men who had no education.

The 1999-2000 BDHS shows that less than half of the women (43 per cent) say they have seen or heard of the green umbrella logo, however, recently introduced as the nationwide symbol for family planning information and services. Women in urban areas are about twice (71 per cent) as likely as those (35 per cent) in rural areas to have seen or heard of the green umbrella logo, knowledge of the logo differs considerably by level of education of the women.

5.5 Reasons for Non-use of Contraception

Despite the fact that men have positive attitudes towards family planning and have also more exposure to the family planning messages, the current prevalence rate of the male methods is still very low. We have discussed here the reasons for not currently using family planning by the married women and men non-users and also their unwillingness to use in the feature.

In 1999-2000 reasons for non-use of contraception among the currently married women show that infecundity (either “menopausal” had hysterectomy or subfecund) is mentioned by the non contracepting women (44 per cent) as the primary reason of non-use followed closely by infrequent sex relations/not having sex and fatalistic attitudes (9 per cent). Reasons of non-use however, differ considerably by age of women. Unfavorable attitude toward family planning (24 per cent) either by women themselves or by their husband, fatalistic attitudes (20 per cent) and religion (9 per cent) are the major reasons for the women below 30 years of age (53 per cent). Older women (30+), on the other hand, normally report reasons such as infecundity (including menopausal) or having no sex/infrequent sexual relations (68 per cent combined).

There are some significant differences in reasons for non use between married women and men. More men (11 per cent) than women (4 per cent) mention that they oppose family planning. Men are also less likely to cite the reason such as infrequent sex / having no sex than women (i.e., 8 per cent versus 16 per cent). Religious prohibition, as the reason of non-use, varies little between men and women. Like women, majority of the men (41 per

cent) also cite infecundity as the most common reason of non-use of family planning 1999-2000 BDHS).

Since 1996-97 there has been a decrease in the proportion of women reporting husband's opposition as the reason of non-use from 9 per cent in 1996-97 BDHS to 4 per cent in 1999-2000 BDHS. Between two survey period (1996-97 and 1999-2000, BDHS), the proportion of men fell from 20 per cent to 4 per cent who said religious prohibition as the reason of non-use. This may be due to the categorisation of the reason (i.e., religion). In the earlier BDHS religious prohibition was used in a broader term than in the 1999-2000 BDHS survey. For example, fatalistic attitude has been shown as a separate category in the latter survey.

The 1996-97 BDHS data revealed that between 11 per cent to 15 per cent of the currently married women and men reported 'want children' as one of the most important reasons for non-use of family panning. Surprisingly, information on this specific reason of non-use has been missing in the 1999-2000 BDHS.

5.6 Inter-spousal Discussion about Family Planning

Lack of desired communication between spouses about family planning may also be a serious barrier to contraceptive use. In the most recent years (1999-2000) over half (52 per cent) of the currently married women said they had not discussed with their husbands about family planning. Of the remaining, while 40 per cent had discussed it twice or less, only 8 per cent had discussed it more than twice. Inter-spousal communication about family planning was less frequent among the very young women (10-14) and the older women.

Since 1996-97, there has been a decline in the proportion of wives talking to their husbands about family planning (more than twice) in the 1999-2000 BDHS survey (i.e., 8 per cent) than in the 1996-1997 BDHS (i.e., 17.3 per cent) (BDHS 1999-2000).

5.7 Differentials in Current Use of Male Contraceptive Methods

Differentials in reported current use of male methods by selected socio-demographic characteristics of the currently married women and married men are shown in Table–4 and 5. Use of condom differs significantly by level of education. Condom use is reported to be much higher among women who have a secondary education or higher (10 per cent) compared to those with some education (i.e., primary complete/incomplete (3 per cent to 4 per cent).

By age, prevalence of condom increases with age of women, reaching highest (6 per cent) for women between 30- 34 years and then declines steeply. By number of living children, women with no living children and those with fewer children (1-2) report the use of condom at a higher rate than those with more children. Vasectomy is pronounced in use among the uneducated and high parity women. Practice of periodic abstinence (PA) differs a little by level of education.

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Practice of PA method reported by women indicates an increasing trend with age, reaching highest (11 per cent) at ages 40-44. Use of periodic abstinence also varies considerably by

number of living children. The use rate is as much as twice (8 per cent) among those women who have more children than those who have a small number of children.

Use of the traditional method, – withdrawal, rises with an increase in the level of education. Women with a secondary education and more report the highest use (6.4 per cent) of withdrawal. By age at very two extreme ends (at early young and old) women report the use at a higher rate. The level of current contraceptive use is higher in urban areas (60 per cent) than in rural areas (52 per cent) among women. There is a considerable difference in condom use reported by women in urban (10 per cent) and rural (3 per cent) areas, probably indicating easier availability of the method in urban areas.

Among the six administrative divisions in Bangladesh, contraceptive use is highest in Khulna division (64 per cent) followed by Barisal (59 per cent), Rajshahi (58.6 per cent) and Dhaka (54 per cent) divisions. On the other had, the two divisions-Sylhet and Chittagong have comparatively lower level of contraceptive use (i.e 34 per cent and 44 per cent respectively (Table – 4). Contraceptive use has increased in all divisions except Rajshahi division since the 1996-97 BDHS survey.

Differentials in male methods use (Table-5) as reported by currently married men are more or less similar to those reported by women, except that the levels of use are generally higher among men. A more precise way to compare discrepancies in contraceptive use reporting men and women is to compare husband and wives.

5.8 Gender Gap in Reporting Contraceptive Use

Gender Differentials in Contraceptive Prevalence Rates in Bangladesh

The disparity between men and women (or husbands and wives) in their reporting of contraceptive use has long been documented in the demographic literature (Yaukey et. al. 1965 Stoeckel and Chowdhury 1969, Green, 1969, Koenig et.al., 1984 Hoplinger and Kuhne, 1984 and Mitra et.al. 1985). The nature of this discrepancy is also well established, with men or husbands reporting greater use of contraceptives than do women or wives.[9] In a recent study, Ezeh et.al. (1996) found current contraceptive use to be higher among currently married men compared with currently married women in 12 of the 14 countries they studied.

In Bangladesh, it (Table 6) shows that there is a significant gender gap in reporting of current use of contraceptives between husbands (64 per cent) and wives (54 per cent). Possible sources of the gender gap in the contraceptive prevalence may be explained as follows:

1. The discrepancy may, in part be due to the assumption that the current contraceptive use is higher among couples in which the husband has extra-marital relations.
2. It is most likely to emerge because of miss reporting and lack of communication between spouses.

[9] Few studies have shown both sexes reporting similar levels of contraceptive use or women (wives) reporting greater use than men (husbands) (see United Nations, 1961, combs and Chang, 1981 and Mott and Mott 1985).

3. The estimates of contraceptive prevalence for currently married men (or husbands) and women (or wives) may differ due to sampling error.

Most researchers have treated observed inconsistencies in contraceptive use status of husbands and wives as respondent-related errors, and in particulars, as under reporting by wives (Koenig et.al., 1984). The gender gap in CPR may also result from gender differences in perceptions of what constitutes contraceptive practice (Ezeh et.al. 1997). For instance a man may report current use of condoms if he used the method recently, whereas a woman may report it only when her partner uses it at every sexual encounter.

5.9 Method-specific Gaps in Bangladesh

The gender differentials are pronounced in reporting of the contraceptives such as pill, condom and periodic abstinence (Table-6). The reported contraceptive use of condom is higher among husbands (6 per cent) than among wives (4 per cent). This may be partly due to extra-marital use or under reporting by wives. The association between extra marital relations and higher incidence of condom use among men has received some attention in the literature (Havanon et.al. 1993). Wives are generally less aware of condom use for STD prevention than are husbands. 5 per cent of wives and 9 per cent of husbands respectively reported current practice of periodic abstinence. PA is the largest source of the gap between husbands and wives. This may be due to differential perceptions of periodic abstinence. [10] Effective practice of periodic abstinence (PA) requires that the individual initiating the action have accurate knowledge of the ovulatory of the cycle. That respondents who report knowledge or use of periodic abstinence (PA) often have an inaccurate understanding of when conception is most likely to occur has been documented (Belcher et.al. 1978). In Bangladesh husbands have least accurate knowledge about the PA method (Grayet.al. ibid.). Although a sizeable proportion of men reports current practice of PA, they are rarely asked questions regarding their knowledge of the ovulatory cycle. For both husbands and wives current practice of PA increases with spousal communication.

One dominant explanation for the gap in contraceptive use between men and women is that individual responses are likely to be influenced by perceived cultural norms and taboos regarding the discussion and practice of contraception (Koenig et.al. 1984). These norms are assumed to operate more for women than for men (Renne 1993).

5.10 Contraceptive Use Reporting Among Married Couples

Among the matched couples 65 per cent of husbands report that they are using a family planning method compared with only 60 per cent of wives (BDHS 1999-2000 p.28).
Again, most of the discrepancy observed in reporting of the use of periodic abstinence (PA), the pill, and condoms is due to couples results from differential statements where husbands say they are using these methods while the wives say they are not using any method at al. Where as at least some of the inconsistencies between the husbands and wives in reporting of contraceptive use could be due to extramarital use, some may be due

[10] A man who periodically abstains from sex for either religious, health or cultural reasons may report that he practices periodic abstinence, whereas a women may only report such abstinence if she practices it during her most fertile period to avoid pregnancy (Ezeh et.al. ibid.).

to misunderstanding of the method (i.e., PA).[11] Another possible reason for the discrepancy may be due to under reporting of contraceptive use by women because of embarrassment or ignorance (for example, use of condom by husband beyond her knowledge).

6. Problem of Male Participation in Family Planning

The problem of male participation in family planning (FP) has at least four dimensions – biological, cultural, economical and technological. As men are not personally involved in the problems and risks of pregnancy and childbirth naturally makes them less responsible. In the majority of traditional societies, the status quo favours men as the dominant gender in all spheres except childcare. The low economic status of women also works against their ability to gain their partner's co-operation to practice family planning. The current emphasis on female methods in most family planning programmes also results from the fact that considerably more research has been conducted on the female reproductive system than on male. Research on male methods has been less intensive and less successful (Gulhati 1986).

6.1 Limited Male Contraceptive Choice

Men have limited contraceptive choices.[12] The complexity of the male reproductive system, lack of adequate funding for advanced research and lack of a balance in men between risks of contraceptive methods and risk of pregnancy and child birth account for the limited availability of male contraceptive methods and developing new contraceptive technology (Agurillaume 1994).

Although the search for ideal male contraceptives that is safe, effective, reversible and acceptable is continuing, the systemic methods including an injectable or implantable hormone for men are as yet experimental and a hypothetical birth control pill for men is yet to be validated with a real pill for men (WHO 1990, Population Reports 1992). Slow progress is due at least in part to the complexity of the male reproductive system. By comparison, the female reproductive system has numerous intervention points (Bremner and Dekretser 1976). However, it is uncertain when improved reversible male methods will become available. New methods of male contraception are many years away from perfection.

6.2 Factors Underlying Low Level Use of Male Contraceptive Methods in Bangladesh

In Bangladesh, despite the fact that men have knowledge about family planning methods and there is favourable attitude towards contraception, current statistics shows low use of

[11] Correct knowledge of the safe period was found to be very low in Bangladesh. In survey, only 25 per cent of men who had heard of safe period were able to give a correct definition (Gray et.al. 1997). Another study (Kamal et.al. 2001) shows that more than 50 per cent of the women in the comparison area of Matlab (users of periodic abstinence) and 18 per cent in the treatment area were incorrectly using the PA method. Almost all of PA. users were users of modern reversible methods and resorted to practice of PA by method switching. In the demographic surveys of every country, reporting of use of 'traditional' methods is inconsistent and probably incomplete (Caldwett, 1985. There is abundant evidence of misreporting in Bangladesh (Gray et.al. 1997).

[12] A serious draw back of the condom, withdrawal and periodic abstinence is men's lack of confidence in their effectiveness. The method's (vasectomy) irreversibility remains the biggest obstacle to its acceptability (Fathalla 1978 and Senanayake 1984).

male methods. This largely indicates their unwillingness to practice family planning. It may be that both the husbands and wives have limited alternative choice of male contraceptives, which they are not willing to use. Among the two modern male methods of contraception, vasectomy is only suitable for men who have completed their family size, while use of condom is not often initiated because of diminished sexual pleasure.

In the early 1980s, sterilisation (both male and female) was a priority programme in Bangladesh. However, in 1987 due to the abolition of target-driven system and payment of incentives to government field workers, service providers and self-appointed agents in the private sector, has slowing down significantly the male sterilisation programme. Men no longer have easy access to information through workers/agents in the government/private sector. Thus, from the highest number of vasectomy cases (2,59,210) in 1984-85, the figure sharply fell to 10,266 in 1995-96 and further to 8000 in 1997-98, a trend that has continued till now (statistical year book ibid). The national family planning programme (NFPP) does not officially encourage use of the traditional methods of contraception (i.e., periodic abstinence and withdrawal). The NFPP does not have any provision to train the field workers about the proper use of these methods. Therefore, they cannot discuss the practice of these methods with potential users, although withdrawal and periodic abstinence currently outweigh significantly the two modern male methods (i.e., condom and vasectomy) in use (i.e., 9.6 per cent Vs 4.8 per cent). Both men and women have no access to accurate information about the proper use of traditional methods, periodic abstinence in particular. The high contribution of the safe period method (periodic abstinence) and azal (withdrawal) to the overall use of male methods in Bangladesh can, however, be hardly over emphasised. Of course, correct use of traditional methods requires excellent spousal communication, discipline, and awareness about the high failure rate of the method. For withdrawal the failure rate in the first year is 18 per cent among typical users, while periodic abstinence has a 20 per cent failure rate in the first year (Hatcher et.al. 1992). From the above discussion, we now turn to the multitude of factors constraining male participation in family planning in Bangladesh. These are discussed as follows:

6.2.1 Lack of Appropriate Public Policy

Historically, the family planning programme in Bangladesh was ushered in the early 1960s with the greatest emphasis on male participation in the programme. From 1965 to 1970 more than one million vasectomies were performed in the country (the then East Pakistan).Even the non-government initiatives, which pioneered the movement of Planned Parenthood almost a decade earlier, were based on a greater participation of males in contraceptive use. Despite such initiatives – both private and public policy interests in male participation in FP gradually plummeted. Most common among the successive regimes has been a lack of appreciation of male participation in FP.

The First Five-year Plan of Bangladesh (1973-78) was very critical about the FP programmes pursued during the Pakistan period. The planners were critical about the programmes being ‘limited mainly to clinical methods such as IUD and vasectomies’ and ‘restricted birth limitation efforts without making an endeavor for all-round family welfare’. The monetary incentive system, particularly the way it was provided, was, however, identified as being ‘most deplorable’. The plan proposed for ‘’a new system of

incentives based on demographic impact rather than on mere acceptance ‘’ (First Five Year Plan of Bangladesh, 1973-78). The policy emphasis further shifted from ‘fertility control’ to ‘reduction in maternal and child mortality and morbidity’, i.e., all-round family welfare. The Bangladesh National Population Policy declared in June 1976 viewed family planning programme as ‘an integral component of total social mobilisation and national development effort with emphasis on both clinical and traditional methods’. Major emphasis in the policy was on various incentive systems for clients and field workers, greater choice of contraceptive mix for clients, and involvement of voluntary organizations in MCH and family planning programmes.

The family planning programme ever since has been focused on an integrated MCH and family planning services and a multisectoral approach for fertility reduction. Successive plans aimed at reduction of Total Fertility Rate (TFR), reduction of Crude Birth Rate (CBR) and improvement of Contraceptive Prevalence Rate (CPR), and respective policy targets were set for different plan periods. Although a cafeteria approach to contraceptive choice has been advocated, there has been no targeting in successive plans for relative use of male and female contraceptive methods. What it implies is that the importance of male participation in family planning gradually lost sight of the policy planners in Bangladesh. There has been very little mentioning in plan documents and policy declarations of the responsibilities of males in family planning choice-mix between male and female methods of contraception. Not surprisingly, therefore, the use of male contraceptive methods shows an increasing trend but not at the desired level.

It is important to note that integration of health and family planning services at the field-level under the Health and Population Sector Programme (HPSP) (1998-2003) has seriously hampered the functioning of the home distribution system of the family planning methods by the field workers at the household level. Under the HPSP, out of a total 18000, so far 9300 Community Clinics (CCs) were built in the country by 2001.The clinics were created to provide maternal and child health care services, including family planning to the rural women. But these health centres remained virtually non-functional due to shortage of staffs and medicine (The Ittefaq, 31 December 2002).

6.2.2 Lack of Institutional Facilities

Despite the institutional facilities of a four-tiered government FP service delivery system in the country (i.e., at the district, upazila, union and ward levels), the existing delivery system is not well-suited to serve the family planning needs of men. For example, at the upazila level, the facilities for male sterilisation are only provided at the upazila health complex (UHC) but the potential clients have difficult access to the health complex due to distance barrier and inconvenient communication system in rural areas, among other factors.

A large number of female field workers are deployed in the government home service delivery programme but they hardly come in contact with adult male members due to socio-cultural constraints and therefore, fail to motivate them to use male methods. Moreover, the field workers are little trained to explain to the couples regarding the relative advantages of male contraceptive methods. At the union level, the FPAs have a little role

to play to motivate the eligible males to practice family planning. Several studies reported gross under-performance of the male staff (i.e., FPAs, MAs, HAs and AHIs) of the Directorate of Health and Family Planning in promoting contraceptive use among males (Ahmed et.al.. 1996).

6.2.3 Lack of Adequate Logistic Facilities

There is lack of appropriate logistic facilities (i.e., clinic, methods, supply and follow-up) for male participation in family planning. Men lack full access to both information and services because their contraceptive needs are neglected by the national family planning programme and its providers. They cannot make informed decisions nor take active part in family planning. No separate clinics/health and family planning service centers for men exist in Bangladesh to counsel men on their reproductive responsibilities and use of contraceptive methods. Inadequacy of logistic facilities for males is reflected in the functional health and family planning (FP) centers both in the public and private sector. Family Planning and health services are delivered at the government upazila health complex (UHC) and the union sub-centers at the upazila level and below and the district Govt. hospitals at the district level. But the family planning services that are provided there are mainly female centered. Separate arrangements for men are non-existent, so they cannot feel their privacy and presence secure there. There are meager follow-up facilities for the male clients and lack of male-trained service providers to do counseling for men. For example, male service providers like Family Planning Assistants (FPA) Medical Assistants (MA), Health Assistant (HA) at the Upazila Health Complex (UHC) are not actively involved with the functions of contacting/motivating eligible males for Family Planning (FP) services. Condoms are distributed at the doorstep through the domiciliary service system. Wives can procure it for their husbands. The family planning programmes of Non-government Organizations (NGOs) now functional in the country concentrate their activities on women-these include service delivery, both through community–based and clinical activities, covering urban and rural population with limited coverage. But these Non-government Organizations (NGOs) do not specifically serve the male needs of family planning.

In urban areas, no separate unit exists for males in the government health and FP centers/hospitals to facilitate the delivery of FP services (for example, desired methods, counseling, vasectomy procedure and follow-up) to men in a private manner. Moreover, augmentation of motivational activities for male contraception among urban population, poor and illiterate in particular is seriously impaired due to lack of male FP workers at the ward level. All these contribute to have a dampening or discouraging effect on male use of contraceptives.

6.2.4 Inadequate Motivational Activities towards Male Participation

The role of information, education and communication (IEC) is highly important in family planning as in any other development programme towards awareness building, motivation and decision-making. However, the experience with IEC activities of family planning in Bangladesh so far has been underlined by its focus on contraceptive use among females.

In the past mass media (i.e., radio, press, print, folk songs) were the main sources of IEC messages to the public, the contents of which were general in approach. Some of the major weaknesses identified in the IEC programme were as follows:

i) lack of audience segmentation and targeted messages.
ii) lack of attention to KAP studies and little synthesising of such studies to aid message differentiation
iii) lack of improved interpersonal communication skills on the part of family planning field workers and
iv) absence of long-term communication strategy[13]

A multi-media approach (i.e., mass media and interpersonal communication) is now being used by the government but in most of the IEC activities (i.e., radio, television, print, folk and face to face contact through field-workers), men have given little importance, although they are half of the reproductive equation. For example, contraceptive use of condom – the male method as the protector of STD/AIDS is not highly stressed in the mass media. Role of male participation in family planning as a joint responsibility of procreation is little pronounced in the display materials. Unlike the female field-workers, male field-workers are not deployed in rural areas to contact the male population to counsel them on the benefits of male methods use. Moreover, the role of old male FP org-
nisers (now designated as FPA) at the union level was changed from motivating males to mainly supervising Female Field Workers (i.e., FWAs).

All these explicitly demonstrate that the conventional IEC programme is quite incapable to focus adequately on men's needs of family planning. Alternative strategies are, therefore, required to cater to the needs of males in the family planning messages. Because different factors are involved in motivating males vis-a-vis females i.e., socio-cultural, religion, medical, gender equality and health. Some cultural taboos will have to be overcome through well-thought IEC strategies. Among the major NGOs, which have IEC programme, the Bangladesh Family Planning Association (BFPA) conveys a variety of activities such as radio programme and others for a long time. The Social Marketing Company (CMC) lays emphasis on mass media for the display of its products (oral contraceptive pill and condom).

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[13] See, UNFPA (1990) Programme Review and Strategy Development Report, Bangladesh, 67p.
But IEC activities tailored to male audience are pronounced a little in the NGO's family planning programme. Finally it can be said that men are attracted to messages that promote positive role, models and appeal to their economic interests.

6.3 Absence of Concern about STDs/HIV

Concern over HIV/AIDS and STDs (Sexually Transmitted Diseases) falls beyond Planned Parenthood and social norms in a traditional society like us. In Bangladesh, there is lack of mass media promotion for AIDS and other STD information. The consequences of STDs can be devastating; women are often the silent victims of STD. Longer-lasting STDs increase the possibility of transmission of HIV virus, which causes AIDS.

STDs are both a medical and social problem. Using condom is the best way to minimize the STD infection associated with patronage of commercial sex. In Bangladesh, the growth of commercial sex industry is thriving, one estimate quotes the figure at 100,000 (Islam 1996) but in reality, the number seems to be much higher. A study report on sexual behaviour by Bangladesh Chapter of Population Council indicates that the premarital sex among unmarried adolescents is very high (published on 26 July 1997, in the Daily Observer). National survey on STDs indicates that almost 50 per cent of the cases prevailing in our country are among the students, who are under 25 years of age. Over 50 per cent of new infections with HIV, the virus that causes AIDS, are now occurring in young people in the 10-24 age group. Even with the low prevalence rate of HIV infection in Bangladesh, Almost 31 per cent are in the age group 16-30 (The Daily Star, January 7, 1999). Widespread premarital sex among the unmarried young is, therefore, a matter of great concern to the nation. To save them from unprotected sex, the young people need access to prevention measures. But condoms are rarely used as a contraceptive method in pre-marital and extra-marital sex relations. There has been little public promotion of condoms specially to prevent STDs other than AIDS in Bangladesh. Hence, ignoring men's participation in family planning and reproductive health services will rather aggravate the situation. Giving little importance to men's needs is likely to greatly increase their health risks, as well as those of their partners. With advent of HIV/AIDS and increasing STDs, the use of condom as a prevention of infection is most essential in marital union, but the current rate of marital condom use in Bangladesh is very low. In this respect, Bangladesh can use the experience of the neighbouring country like Thailand. The high rates of condom use currently reported there is the combined result of the government's firm policy of requiring condom use at brothels or at similar establishments where commercial sex is available and heightened fear of the consequences of infection with HIV (Knodel et.al.. 1996). While temporary use of condoms by married couples can be helpful in preventing the spread of STDs, only consistent long-term use can be effective against the transmission of HIV.[14]

To arouse awareness about the seriousness of deadly diseases (i.e., HIV/AIDS) among the different section of people (such as truck drivers, prostitutes etc.) in the contry, some of the Non-government Organisations (NGOs) working in this area may be mentioned as follows:

i) Christian Communication Development in Bangladesh (CCD'B)
ii) AL-FALAH, Bangladesh 9iii) MISUK (iv) SURUKA Prokaslpa (v) VOW
(vi) ADRA (vii)Jagrato Jubo Sangha (viii) Ahakti Prokalpa (ix)Care- Bangladesh
and (x) Marie Stopes Clinic Society (MSCS). The last one gives treatment to STDs to the clients, in addition to creation of mass-consciousness about the diseases (Hossain 2000).

6.4 Lack of Concern of Men's Reproductive Health Needs

[14] There are countries where the rate of marital condom use is high. Among the 119 countries for which the United Nations has recently compiled statistics on contraceptive method use, there were 18 in which at least 10 per cent of couples of reproductive age reported currently using condoms. In eight of these countries – including Japan and Singapore – the rate of marital condom use was at least 20 per cent among couples of reproductive age High marital condom use in Japan is in part a result of legal restrictions on the availability of other contraceptives (United Nations, 1994).

In Bangladesh, no effective measures have been adopted in the national FP programme to emphasise men's shared responsibility and promote their sexual and reproductive behaviour, including family planning. It is noticed that men often have a poor understanding of their reproductive health because they are approached with a female focused FP programme. This programme pays little attention to the reproductive health services that men need. As for example, the sexual disease (i.e., sexually tract infections – STIs) is little stressed in the national programmes. There is also lack of information on responsible sexual behaviour for the adolescents and the youth. Provider bias does affect male services. As one UNFA report on male involvement summaries as follows:

Most reproductive health/FP service delivery systems are almost entirely oriented to women and provide little or no information about male contraceptive methods. Health workers are sometimes poorly trained in counseling men about safer sexual practices and male methods and may communicate negative rumors about them (Green et.al. 1995). It wholly applies to the present situation in Bangladesh.

6.5 Discrepancy in Man's Dual Role: As Policy Planners and Contraceptive Users

Men as policy-makers and service providers largely dominate the health and FP programmes in Bangladesh but their roles as users of contraceptives is contrary to our expectation (i.e., unexpectedly low).[15] Same is the situation in the whole Asian subcontinent where the majority of programmes and policy managers at the top levels of national programmes are men. Despite the fact, the low level of male participation in family planning seems to be incompatible. The sheer discrepancy in man's dual role as policy makers and contraceptive users is self-defeating. It seems to point out the constraints persisting in the current female focused FP programme, which does not encourage men to use contraceptives. Moreover, little is known about the contraceptive use of the family planning policymakers since no study of this sort has been probably undertaken in Bangladesh.

6.6 Field Observation about Male Participation

Based on the conversation with the Family Planning Officer, Medical Officer (MCH & FP), Family Planning Assistant and others of the Upazila Health Complex of Akhaura, Brahmanbaria, as regards the status of male participation in family planning in the said upazila (i.e., Akhaura) are provided below :

Men and women have fair knowledge of family planning and positive attitude towards contraceptive use. The Contraceptive Prevalence Rate (CPR) in this upazila is higher (69 per cent) than the national average rate. Oral contraceptive pill is the single major method in use. Next to it are, in order of importance, injectable, female sterilisation, condom, IUD and far less, Norplant. Vasectomy is least pronounced in use. Like other parts of the country, contraceptive prevalence is highly dominated by female methods. As the

[15] According to the available information in 1996 , the position of male providers in the directorate of health and family planning is as under:
' In the Health Directorate, there are almost 6000 physicians, at least three-fifths of them are males out of 18,579 health assistants (HAs), 14,381 are male HAs'In the Family Planning Directorate, out of 1092 sanctioned positions for doctors, as many as 752 male and 129 female doctors are now posted. Out of 2300 Medical Assistants (MAs), as many as 1995 are in position. In the FP programme, there are more than seven thousand field-staffs (FPIs, MA and family planning NGO staff (Alauddin and Zaman 1996).

traditional methods of contraception (i.e., withdrawal and periodic abstinence) are not covered by the government family planning programme, no information on use of these methods could, therefore, be given here.

Apart from that, the proportional share of modern male methods to the overall use of contraceptives is very low. The permanent male method – vasectomy - is the least preferred method to men (or husbands) in the upazila, Akhaura. In consistent with the national acceptance rate of vasectomy, the use rate of this method is significantly low (i.e., less than 1 percent). That is, 0.68 per cent of the eligible married couples (143 out of total 20934) in the upazila reported to be current users of vasectomy compared to 8.4 per cent of those of tubectomy. The situation is more deplorable because the acceptors of vasectomy are sharply declining (for example, only one vasectomy case was reported in the month of August 2001).

One interesting reason, as reported, hindering the acceptance of vasectomy is that the eligible wives do not like their husbands to be sterilized. They apprehend that undergoing operation (i.e., vasectomy) is most likely to create various health complications for their husbands, such as, loss of virility, physical weakness and decrease in ability to work.. Another important reason is that motivational work for use of this method is strikingly low. Field-workers (male) show little interest in motivating men to undergo vasectomy procedure because of less incentive for this job. Women (or wives) do not prefer men (or husbands) to adopt the permanent male method arguing that they are ready to take the responsibility of contraceptive use rather transferring the burden to their husbands. With regard to low use of male methods in the upazila, the medical officer (MCH & FP) of the health complex expressed the views as follows:

- Male methods covered by the national FP programme are condom and vasectomy. National programmes ignore the traditional methods of withdrawal and periodic abstinence. The result is that men have limited alternative choice of the methods of contraception.
- The two methods (i.e., condom and vasectomy) are not attractive enough to the married couples.
- Because of respective disadvantages of these two methods (i.e., reduced pleasure of condom use and irreversibility of vasectomy), the doctors or the concerned family planning staffs can hardly motivate men to use them.

In favour of possible increase in male involvement in contraceptive use, the opinions suggested are as follows:

There is now sheer unwillingness on the part of men to use either of the two methods (i.e., condom and vasectomy) as the preferred methods. To overcome the constraints, it requires a variety of new male methods, which are safe, comfortable in use, and cost-effective and of good quality. If these are made available, it would become easier to motivate men to use male methods more. Moreover, men's unwillingness to practice family planning would decline gradually with expansion in the male method-mix. As a consequence, the

contraceptive needs of men could be better served than before suiting to their personal choice, economic interests, culture and social norms.

From the discussion above, it appears that male participation in family planning is seriously hindered by paucity of a desired number of modern male methods of contraception. In addition, no message about the use of 'natural' methods is conveyed in the national FP programme. At the field-level, efforts directed towards motivating the large male populations in rural areas to use male methods (i.e., condom and vasectomy) are discouragingly low. More importantly, the special role of condom use to check the transmission of infection of HIV virus-causing AIDS is not explained at all to the vast rural masses, who have little knowledge of the deadly disease. All these imply that targeting men actively in family planning should be given proper attention in the national FP programme.

7. Potential of Male Participation in Family Planning

7.1 Realisation of the Importance of Male Participation

There is now a realisation of the growing importance of male participation in family planning (FP) which emerges from the fact that the females now shoulder largely the contraceptive burden. To ease the burden, men should therefore, play a greater role in contraceptive use as a joint and equal responsibility. A high level of contraceptive prevalence in most of the developing countries can be achieved through increased involvement of men in family planning. For example, practice of male contraceptives share half of the current CPR in Turkey.

7.2 Important Implications on Health Needs of the Couples

Practicing family planning by males is now well-recognised to have important implications on health needs of the couples. For example, use of the male method (i.e., condom) may relieve women of various health risks posed by their prolonged use of oral contraceptives (Bruce stokes, 1980). Despite the recognition that condom can serve as a means of contraception, their primary association is with Sexually Transmitted Diseases (STDs) prevention. Moreover, the most effective technology against the spread of HIV/AIDS is still condom.

7.3 Use of Contraceptive Methods Based on Gender Equality

On grounds of gender equality, responsibility for birth control should be shouldered by men and women alike. It is, therefor, emphasised that further increases in the existing level of contraceptive prevalence must come progressively from use of the methods, which require male participation. The ultimate success of family planning based on total family welfare rests on maintaining a balance in the choice of mix of gender-oriented contraceptives. In the developed countries high CPR demonstrates (though not always) the compliance of equity in the use of gender-specific contraceptives.

7.4 Cost -effectiveness of Male Methods

Using male contraceptives seems to be the most cost-effective way of promoting contraceptive prevalence level. For example, vasectomy is less costly and invasive than female procedure (Ross et.al. 1993). A new no-scalpel method of vasectomy (NSV) makes a very safe procedure even safer and easier for the client. Condom is low cost. In terms of side effects, male methods have few problems. The traditional methods (i.e., withdrawal and periodic abstinence) are readily available, with no side-effects and cost-free. But the failure rate of traditional methods is high, it is also not an effective method.

7.5 Sustainability of Family Planning Programme through Male Participation

Failure to actively involve men in family planning is most likely to retard the pace of increase in prevalence. In general men possess a higher potential contribution to FP service delivery as well as in the extension of relationship between partners and improved communication regarding reproductive goals within the present patriarchal system (Green et.al. 1995). This fact recognizes the need to encourage male contraception with increased efforts and it is also important to enhance the sustainability of the FP programme.

7.6 Scope for Improving Alternative Male Methods

When a variety of contraceptive methods are available for men, male participation in FP is likely to increase. New methods of male fertility regulation currently undergoing clinical trials, have the potential of being effective as well as reversible, non-surgical and long-acting (WHO 1990, Waites 1992). The introduction of new safe and improved male methods will substantially alter the willingness of men to take responsibility for fertility regulation and this will ultimately lead to an increase in contraceptive use (Ringheium 1993 Leriden 1986 and UNFPA 1990).

7.7 Prospects of Male Participation in Bangladesh

7.7.1 Men's dominance in the health and family planning sector

In the health and family planning (FP) sector, males dominate the policy-making body at the national level. Moreover, males constitute a great majority of the service providers (see, foot-note.17). The large number of male workers (i.e., Health Assistants - HAs) at the field-level have the potential to serve men for family planning and prevention of Sexually Transmitted Diseases (STDs), in particular. As such, there is tremendous unexploited potential for male to male education and counseling for promoting male methods by the government and the NGO programme male staff. In view of the potential threat of HIV/AIDS in the country, the national FP programme has the great scope to focus and emphasize on increased use of the male method-condom.

7.7.2 There is established network of FP services, information and counseling at clinical facilities. Networks of both the sectors (i.e., government and non-governmental) where contraceptive methods for men are available, can be utilised for male initiative programme.

7.7.3 Reproductive health needs of men can be served by centres, to be created in the government hospitals, where male doctors are posted. The doctors can be trained in family planning activities and other aspects of male involvement. Moreover, men have convenient access to condoms through the existing social marketing programme. This can help promote contraceptive use of condom by concerted motivational efforts.

7.7.4 In Bangladesh, BCC (Behaviour Change Communication) programmes are expanding and have the potential to include male focused activities. Moreover, mass media can be effectively used for reaching men for creating awareness among them about the severity of the deadly disease (i.e., HIV/AIDS). This will, in turn, educate them to take the primary preventive measures against the transmission of infection of the HIV-virus.

7.7.5 The government FP programme continues to enjoy favourable and stable political support in the country. This immense opportunity can be utilised to place the important issue of male involvement in family planning at the national level in an egalitarian manner to gain emphatic public support. It, therefore, implies that exploring various potential avenues of male programme development in Bangladesh can augment the seemingly low level of male participation in the family planning programme.

8. Conclusion and Policy Recommendations

Despite the fact that men have practiced birth control for years, they have generally been excluded from organised family planning programmes. In Bangladesh, men's potentially positive role in family planning has also been neglected because of female bias in FP programmes. The present contribution of male methods to the overall contraceptive use is strikingly low. This militates against the principle of gender equity in method use. The ultimate success of family planning based on total family welfare rests on maintaining a balance in the choice of a mix of gender-oriented contraceptives. In the developed countries high level of contraceptive use demonstrates the compliance of equity in the use of gender-specific contraceptives.

From 1996 to 2000, the total CPR in Bangladesh had increased by 5 per cent (i.e., from 49 to 54 per cent) and the increased use was more pronounced in the case of male methods (19.3 per cent) compared to the female methods (6.2 per cent). Of the male methods, while use of the traditional methods (i.e., withdrawal and periodic abstinence) increased significantly (i.e., 36.2 per cent) condom registered a small increase in use (i.e., 10 per cent). On the other hand, use of the long-term male method (i.e., vasectomy) declined to a negligible figure. Promoting the use of these two methods (i.e., condom and vasectomy) is highly important such as (i) vasectomy is the most cost-effective method and (ii) condom, beyond family planning is also used as an effective means to preventing the transmission of HIV/AIDS.

Indeed, oral pill- the female method is now continuing to be the single major method in the overall use-pattern of contraceptives in Bangladesh. Reducing much reliance on this method (pill) will, therefore, require a change in the present expensive home service delivery system. This can be done by changing the behaviour of the eligible couples through motivational efforts and to the use of the newly created community clinics at their close proximity. This will help to reduce much dependence on the oral contraceptive and switch to use of the male methods of contraception, condom in particular. In Bangladesh, many women achieved their desired family sizes, which is currently 2.5, at an early age, and are thus, in need of a further fifteen or more years of continuous protection against pregnancy (Khan et.al.. 2001). More importantly, 15 per cent of the currently married women have unmet contraceptive needs (BDHS 1999-2000), probably half of them for limiting purposes. It implies that permanent contraceptive methods have a vital role to play in the reduction of fertility in Bangladesh. In recent years, the steep decline in the use of permanent methods (i.e., male sterilisation, in particular) shows rather a disappointing performance in the country. The most two major reasons mentioned in the study (Khan et.al. ibid) for not accepting the permanent method (sterilisation) were, such as, (I) dislike of the method by husbands and wives and (ii) fear of operation.

Spiler and other experts say ‘if the role of men in family planning is to expand significantly in the near future, that will mean greater use of vasectomy” (Net-work 1992). In this perspective, the male permanent method (i.e., vasectomy procedure) can be made popular in Bangladesh by adoption of well-thought measures (for example, quality of services, adequate motivational efforts, proper counseling and follow-up etc.) This is, in turn, most likely to help achieve greater acceptance of male sterilisation. The continuing, increase in the traditional male methods (i.e., withdrawal and periodic abstinence) signify that the national-FP programme can hardly ignore contribution of these methods to the overall contraceptive prevalence in the country.

The following recommendations may be put forward for successful implementation of the male-oriented family planning programmes in Bangladesh.

- Structural changes are needed in the current national family planning programme, giving more emphasis on broader participation of men in family planning.

- Men’s awareness should be raised in order to ensure responsible parenthood by wide publicity through mass-media (i.e., radio, television and newspapers etc.)

- Male focused Behaviour Change Communication (BCC) activities need to be undertaken to motivate and inform men about the benefits and choice of male methods according to their needs.

- The contents of training programme of the field-level workers and supervisors need to be modified, laying emphasis on male motivation for family planning. In this respect, the community clinics, the first-level facility to the rural population, can better serve men by giving necessary information, support and method.

- Provisions may be made for creation of separate unit in the upazila health complex (UHC) to give more attention to reproductive health needs of men, including family planning.

- Community participation is an indispensable factor to promote greater male participation in family planning. Community out-reach is necessary to male involvement efforts which include among others using local leaders, influentials, field-workers, CBD distribution, and traditional healers etc. All these can serve as sources of information, counseling, supplies and referral for family planning services.

- 'Pallichikithshak' (village practitioners) who play a key role in the rural health care delivery system and local-level government institutions (i.e., union council, upazila parishad and municipality etc) should be involved in family planning programme.

- Private sector and NGOs in male family planning programme should be encouraged.

- Provision may be incorporated in the national FP programme to provide information, counseling and education on proper use of the traditional male methods of contraception.

- Over and above, male programmes should be an important part of the government health policy to promote reproductive health.

List of Tables

Table 1: Percentage of Currently Married Women Age 10-49 Who are Currently Using Specific Family Planning Methods

Method	*1975 BFS*	*1983 CPS*	*1985 CPS*	*1989 BFS*	*1991 CPS*	*1993-94 BDHS*	*1996-97 BDHS*	*1999-2000 BDHS*
Any method	7.7	19.1	25.3	30.8	39.9	44.6	49.2	53.8
Any modern method	5.0	13.8	18.4	23.2	31.2	36.2	41.5	43.4
Pill	2.7	3.3	5.1	9.6	13.9	17.4	20.8	23.0
IUD	0.5	1.0	1.4	1.4	1.8	2.2	1.8	1.2
Injectables Implant/Norplant	-	0.2	0.5	0.6	2.6	4.5	6.2 0.1	7.2 0.5
Vaginal method	0.0	0.3	0.2	0.1	U*	U	U	U
Condom	0.7	1.5	1.8	1.8	2.5	3.0	3.9	4.3
Female sterilisation	0.6	6.2	7.9	8.5	9.1	8.1	7.6	6.7
Male sterilisation	0.5	1.2	1.5	1.2	1.2	1.1	1.1	0.5
Any traditional method	2.7	5.4	6.9	7.6	8.7	8.4	7.7	10.3
Periodic abstinence	0.9	2.4	3.8	4.0	4.7	4.8	5.0	5.4
Withdrawal	0.5	1.3	0.9	1.8	2.0	2.5	1.9	4.0
Other traditional methods	1.3	1.8	2.2	1.8	2.0	1.1	0.8	0.9

*U= Unknown

Source : 1975 BFS (Islam and Islam, 1943:43); 1989 CPS (Mitra and Kamal, 1985 :159) 1985 CPS (Mitra 1987:147); 1987 BFS (Huq and Cleland, 1990:64); 1991 CPS (Mitra etal); 1996-97 BDHS (Mitra et.al., 1994: 45); 1999-2000BDHS (Mitra et. al.).

Table 2: Percentage Share of Male Methods to the Contraceptive Prevalence Rate

Method	*1975 BFS*	*1983 CPS*	*1985 CPS*	*1989 CPS*	*1989 BFS*	*1991 CPS*	*1993-94 BDHS*	*1996-97 BDHS*	*1999-2000 BDHS*
Contraceptive Prevalence Rate (CPR)	7.7	19.1	25.3	31.4	30.8	39.9	46.6	49.2	53.8
Participation of any male method	2.6	6.4	8.0	8.4	8.8	10.4	11.4	11.9	14.2
Condom	0.7	1.5	1.8	1.9	1.8	2.5	3.0	3.9	4.3
Vasectomy	0.5	1.2	1.5	1.5	1.2	1.2	1.1	1.1	0.5
Periodic abstinence	0.9	2.4	3.8	3.8	4.0	4.7	4.8	5.0	5.4
Withdrawal	0.5	1.3	0.9	1.2	1.8	2.0	2.5	1.9	4.0

Source : 1975 BFS (Islam and Islam, 1943:43); 1989 CPS (Mitra and Kamal, 1985 :159) 1985 CPS (Mitra 1987:147); 1987 BFS (Huq and Cleland, 1990:64); 1991 CPS (Mitra etal); 1996-97 BDHS (Mitra et.al., 1994: 45); 1999-2000BDHS (Mitra et. al.).

Table 3: Trends in Relative Share of Male Methods Use to the Contraceptive Prevalence Rate

(in percent)

Year / *Level of Use*	*1991 CPS*	*1993-94 BDHS*	*1996-97 BDHS*	*1999-2000 BDHS*
Contraceptive Prevalence Rate (CPR)	39.9	44.6	49.2	53.8
Share of all male methods to the CPR	26.1	24.5	24.2	26.4

Source : 1975 BFS (Islam and Islam, 1943:43); 1989 CPS (Mitra and Kamal, 1985 :159) 1985 CPS (Mitra 1987:147); 1987 BFS (Huq and Cleland, 1990:64); 1991 CPS (Mitra etal); 1996-97 BDHS (Mitra et.al., 1994: 45); 1999-2000 BDHS (Mitra et. al) .

Table 4: Percent Distribution of Currently Married Women Age 10-49 Contraceptive Method Currently Used, According to

Selected Background Characteristics

Background characteristic	*Any method*	*Any modern method*	*Modern method*		*Traditional method*	
			Condom	*Male sterilisation*	*Periodic abstinence*	*Withdrawal*
Age						
10-14	25.7	16.1	3.8	0.0	3.1	6.5
15-19	38.1	31.2	4.3	0.0	3.2	3.5
20-24	47.1	40.1	40	0.1	3.2	3.5
25-29	58.1	49.0	4.3	0.2	4.3	4.1
30-34	64.2	53.0	6.1	0.6	5.8	4.1
35-39	67.7	53.8	4.2	0.9	7.8	4.7
40-44	61.9	43.5	3.6	1.4	10.7	5.6
45-49	43.1	31.7	1.7	1.8	7.5	2.8
Education						
No education	51.0	41.5	1.0	0.8	5.4	2.9
Primary incomplete	53.3	44.0	3.4	0.5	5.4	3.4
Primary complete	52.7	41.5	4.3	0.2	5.7	4.2
Secondary +	59.1	47.0	10.2	0.1	5.2	6.4
Number of living children None	20.6	13.5	5.1	0.1	2.6	4.6
1	48.9	40.6	5.0	0.3	4.5	3.5
2	61.0	52.5	5.2	0.5	4.2	3.6
3	64.8	53.5	3.7	0.4	5.6	4.9
4	58.5	44.5	2.9	0.9	8.1	4.0
Area/Division						
Urban	60.0	48.7	9.8	0.4	5.4	5.2
Rural	52.3	42.2	2.9	0.6	5.4	3.8
Division						
Barisal	59.2	45.7	2.9	1.7	6.9	6.0
Chittagong	44.0	34.9	3.6	0.1	5.0	3.0
Dhaka	53.9	42.1	5.0	0.2	5.9	5.0
Khulna	64.0	50.9	6.6	1.0	6.7	6.0
Rajshahi	58.6	51.1	3.3	0.7	3.6	2.9
Sylhet	34.0	25.0	3.0	0.3	7.3	1.2

Source: BHDS 1999-2000

Table 5: Percent Distribution of Currently Married Men by Contraceptive Method Currently Used, According to Selected Background Characteristics

Age	*Any*	*Any modern*	*Condom*	*Male*	*Periodic*	*Withdrawal*

	method	***method***		***sterilisation***	***abstinence***	
20-24	56.9	47.4	8.4	0.0	7.1	2.4
25-29	52.9	41.2	7.2	0.0	9.8	1.1
30-34	60.2	49.9	7.2	0.6	7.6	1.7
35-39	69.0	58.2	4.4	0.3	7.8	1.4
40-44	68.3	57.6	4.1	0.4	8.0	1.7
45-49	74.8	58.2	8.3	1.0	10.0	5.4
50-54	68.2	53.0	6.1	3.7	12.6	2.7
55.59	45.0	28.7	1.0	1.7	14.1	1.8
Education						
No education`	57.2	47.6	2.5	1.4	7.9	0.8
Primary incomplete	61.1	47.0	3.0	0.9	11.2	1.4
Primary complete	64.5	55.3	5.1	0.0	8.1	0.8
Secondary +	71.1	56.9	11.5	0.2	9.2	4.3
Number of living children						
None	30.9	22.4	9.3	0.0	7.7	0.9
1	59.3	47.5	6.2	0.3	9.0	2.0
2	73.2	62.4	7.7	1.1	8.4	1.9
3	73.1	61.7	4.6	1.1	8.8	2.3
4+	64.0	49.0	4.2	0.9	10.3	2.8
Residence						
Urban	68.3	56.2	11.3	0.6	9.1	2.3
Rural	62.3	50.1	4.6	0.8	9.2	2.1
Division						
Barisal	66.6	49.4	3.2	1.2	12.2	3.5
Chittagong	57.3	46.9	5.1	0.0	7.7	2.3
Dhaka	59.7	46.6	6.5	0.7	9.8	2.3
Khulna	72.9	56.8	7.9	0.5	11.9	3.7
Rajshahi	71.2	61.5	5.2	1.5	7.2	1.3
Sylhet	40.6	30.7	6.6	0.0	9.2	0.2
Total	**63.5**	**51.3**	**5.9**	**0.8**	**9.1**	**2.2**

Source: BDHS 1999-2000.

Table 6: Percent Distribution of Currently Married Women and Men by Use of Contraceptive Methods

Method	***Currently married women***	***Currently married men***
Any Method	53.8	63.5
Any modern method	43.4	51.3
Pill	23.0	28.6
IUD	1.2	1.3
Injectable	7.2	7.2
Condom	4.3	5.9
Female Sterilisation	6.7	7.1
Male Sterilisation	0.5	0.8
Norplant	0.5	0.3
Any traditional method	10.3	12.2
Periodic Abstinence	5.4	9.1
Withdrawal	4.0	2.2
Other method	0.9	0.7

Source: BDHS 1999-2000

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