

Integration of Reproductive Health Services for Men in Family Welfare Centers

What Men Want

Responsible men all over the world are open to new information, new understanding, and new approaches to help them become full partners in better reproductive health. Men in Bangladesh are no different, and the Population Council's Frontiers in Reproductive Health Program is working to develop an effective way to reach men with new services and new information about their reproductive health.

Men, as well as women, play key roles in reproductive health, including family planning. Traditionally, increasing men's participation has been difficult. Most family planning and reproductive health research and services in Bangladesh, as elsewhere, target women. Reproductive health has not addressed a large number of issues concerning men. It is assumed that men are difficult to reach and that they are resistant to changes in their reproductive attitudes and behavior.



But a growing number of family planning and other reproductive health care programs and providers are seeing that men deserve more attention—for their own sake, for women's sake, and for the health of their families and communities. From this new perspective, men are potential partners in and advocates for good reproductive health rather than adversaries.

Bias towards Women's Health

Since the mid-1970s, the National Family Planning Program in Bangladesh deliberately motivated women to use modern contraceptive methods and encouraged them to seek services from static clinics. Women health workers were recruited to serve female clients at home. While this policy may be effective for reaching women, but one point is very clear: men are



ignored. As a result, men routinely seek medical advice from private practitioners, hospitals or pharmacies (for acute episodes of illness), and they ignore preventive care aspects and postpone seeking care for chronic conditions (Piet-Pelon and Rob 1997, Population Council 1996a).

Even rural health and family planning infrastructure essentially support and address women’s health needs.

Box 1: Male Participation in Reproductive Health Care

- Male FP methods were only 15 percent of the FP method mix
- Men were reluctant to use condom
- Men felt shy in seeking services for RTI/STIs
- Very few men accompany their wives for antenatal care (ANC) and postnatal care (PNC) services
- Men have sex with their partners while they are (unknowingly) infected

There are 350 *Upazila* Health Complexes (UHCs) at the *Upazila* (sub-district) level and 3,700 Health and Family Welfare Centers (HFWCs) at the union (lowest administrative unit covers 30,000 to 50,000 population).

Health and Family Welfare Centers (HFWCs) offer remedial and preventive services to both mother and child. Each HFWC is staffed by Family Welfare Visitors (FWVs) and Sub-Assistant Community Medical Officers (SACMOs). FWVs are traditionally women who have received 18 months of basic training in reproductive and child health care. They provide family planning (FP) and maternal and child health (MCH) services. SACMOs are predominately male with three years of basic training in reproductive health (RH), child health care and basic medical services. They provide general

health care, child health care and treatment for minor ailments.

Men Make a Difference

Like women, men have reproductive health concerns that change as they move through their life cycles. In the absence of reproductive health education and with the flourishing practices of traditional healers, appropriate program efforts are needed to educate males. Men lack proper knowledge of the signs and symptoms of reproductive tract infections (RTIs), the modes of transmission and means of prevention. One of the most important reasons for this lack of knowledge is the lack of program efforts to address these needs (Box 1).

The high prevalence of sexually transmitted infections (STIs) among women in Bangladesh is an indirect indicator of the high prevalence of these diseases in men (Population Council 1996b; Wasserheit et al. 1989; Hussain, Rahman and Begum 1996). Women are generally ignorant about the signs and symptoms of male STIs, and many men engage in risky sexual behaviors while they are infected. There is a growing realization that unless men are reached, program efforts in women’s reproductive health will have limited impact (Directorate of Family Planning, NIPORT and Population Council 1998). The current female-focused FP/MCH service delivery system in Bangladesh offers little scope for addressing the reproductive health needs of men. The challenge is finding ways to reach men using the existing resources of the public health care service delivery system in Bangladesh.

A New Approach

The Bangladesh government’s focus on improving the quality of rural health care is demonstrated by its commitment to construct community clinics for a population exceeding 6,000 in the rural areas. These community clinics are "one-stop" service centers that provide an essential service package (ESP). More than 5,000 community clinics, many of which are operational, have already been constructed. Each clinic is equipped with trained Health Assistants (HAs) and Family Welfare Assistants (FWAs). These lowest-level health providers are positioned to act as change agents by catering to the reproductive health needs of both men and women.

Box 2: Study Objectives

- Increase access to RH services for men at HFWCs, especially for STI/RTIs, vasectomy and sexual health counseling
- Modify existing BCC materials to increase the acceptance of male RH services and couple communication
- Revise and utilize existing service protocol for men
- Assess the management, technical and financial implications of integrating male RH services into the existing service delivery system
- Improve community outreach activities and assess the impact of BCC activities

Operations Research Study

The Population Council in collaboration with the National Institute of Population Research and Training (NIPORT) is conducting an operations research study with the goal of increasing access to and acceptability of reproductive health services and information for men within the existing government health care delivery system. The study seeks to break down social and cultural barriers against male health issues by educating health staff to overcome ignorance and prejudices about men. The project began in November 2000 and will be completed by the end of 2002. NIPORT is an apex institute in the field of research and training under the Ministry of Health and Family Welfare. All intervention activities are being undertaken by NIPORT. This *Research Update* describes the initial phase of the study.



Study Design

This study uses a quasi-experimental non-equivalent control group design, with eight HFWCs selected as intervention sites and four selected as control sites. The experimental and control areas were selected purposely from the four largest administrative divisions of the country (two experimental and one control HFWC from each division). The experimental group will have a twelve-month intervention period.

Box 3: Contents of Training

- Essential service package (ESP) (RH, child health care, communicable disease control, limited curative care and BCC)
- Safe Motherhood elements (e.g., ANC and PNC)
- Family planning
- Concept of gender
- RTIs, STIs (genital ulcer, vaginal discharge, urethral discharge and scrotal swelling) and HIV/AIDS)
- Syndromic management of RTI/STIs
- Couple communication
- Counseling on sexual health
- Role of men in couple's reproductive health care

A management committee was formed comprising members from Directorate of Family Planning, NIPORT and the Population Council to implement project activities at the beginning of the project. A three-member team, chosen by the project management committee, visited the selected *upazila* and identified the HFWCs for intervention. The HFWCs were selected on the basis of the presence of assigned staff, proximity to urban areas, and robust infrastructure. The intervention areas were Sohagi and Maijbagh from the Dhaka division, Khornia and Atlia from the Khulna division, Mongalpur and Forokkabad from the Rajshahi division and Alinagar and Lowtha from the Sylhet division. From the adjacent *upazila* a third HFWC, having almost identical characteristics as the experimental HFWCs, was selected as a control site.

Preparatory Activities

Orientation Workshops with District and Upazila Level Managers: Two orientation workshops were organized for the district and *upazila* level program managers posted in the project areas. At these workshops, the participants were informed about the study objectives, implementation plan and strategy. Participants at the workshops included the Civil Surgeon, Deputy Director of Family Planning, *Upazila* Health and Family Planning Officer (UHFPO), *Upazila* Family Planning Officer (UFPO), Medical Officer



(MCH-FP), Principal, Family Welfare Visitors Training Institute (FWVTI) and Training Officer at the Regional Training Center (RTC).

Focus Group Discussions with Program Managers and Trainers: Four focus group discussions (FGDs) were conducted with the program managers to assess their knowledge about RH problems of men, availability of services, management and logistic issues, existing behavioral change communication (BCC) materials for men, and training needs of the workers. In addition, the FGDs solicited the participants' views on the implementation process.



Participatory Workshop for Reviewing and Developing a Training Manual: After identifying the training needs of the workers, the program managers reviewed available materials and developed a training manual for the trainers in a three-day workshop. During the preparation of the manual, program managers thoroughly reviewed the existing essential service package (ESP) manual and adapted appropriate sections from it (Box 3).

Box 4: Service Provider Level Interventions

- Assessment and mobilization of existing resources
- Review and development of training materials
- Training of health care providers on RTI/STIs
- Refresher training for health care providers
- Review, development and distribution of BCC materials
- Development and introduction of monitoring check list

Situation Analysis: A modified situation analysis was conducted by NIPORT using both qualitative and quantitative methods, including interviews with service providers, FGDs with community leaders, collection and review of the existing BCC materials, and collection of service statistics. A complete inventory of facilities including equipment, supplies and staff available at each delivery point was conducted.

Development of Behavioral Change Communication (BCC) Materials: Seven different BCC materials were developed by NIPORT to fill existing gaps in BCC materials for males. These included five posters on

the availability of male services at HFWCs, use of condoms, signs and symptoms of STIs, dangers of STIs and their management, and non-scalpel vasectomy (NSV). In addition, one leaflet and one brochure were developed covering male RH problems.

Interventions

The study's experimental intervention package was developed using the results of the situation analysis. The interventions were introduced in a gradual, phased-in manner at three distinct levels: service provider, clinic and community, so that service providers could accommodate the increase in the clinic's daily case load, and the type of care that they provide (Boxes 4, 5 and 6).

Service Provider Level

Training

Upazila and district level officials conducted a five-day training course for FWVs, SACMOs, FWAs and HAs. 102 workers attended the training course. A three-day theoretical training course was organized at each UHC or RTC, followed by a two-day hands-on practical training course for each of the HFWC's service providers (FWA and SACMO only). After completion of the training program, service providers returned to their work places and spent at least two weeks practicing their newly acquired skills.

The contents of the training were identified at the program managers' participatory workshop. The majority of the topics were adapted from the ESP training manual, however, additional topics were added that related to men and sexuality, such as counseling on sexual health matters and the role of men in reproductive health. The

providers received counseling skills training to help them discuss sensitive issues related to couple communication on sexual health matters. The training methods included lectures, demonstrations, role-playing and group discussions. The MO (MCH-FP) of the respective *upazila* conducted hands-on practical training.



Review workshop

A review workshop was organized for the program managers two months after the training. The objectives of the workshop were to review the project activities, share experiences, assess performance, discuss difficulties faced and debate emerging issues. The review meeting clearly revealed that service providers needed more training on clinical aspects of RTIs/STIs and their management. Issues surfaced relating to the shortage of medicines due to the increased number of male clients. Program managers assured supply of the required resources.

Clinical training program

A five-day clinical training program was arranged at the Skin and Venereal Disease Department of the nearby Medical College Hospital. The head of the department or his representative conducted the training sessions for supervisory staff and service providers from the experimental areas. The principal of the FWVTI organized the training course. This higher level training focused on the diagnosis and treatment of RTI/STIs. Participants also had the opportunity to observe male patients who came for services and to participate in case management.

Clinic Level

Improved service delivery

Special emphasis was given to maintain privacy during consultations. Considering cultural sensitivities, female clients were seen by FWVs and male clients by SACMOs. After the training, service providers began offering all services including FP methods, counseling and treatment for RTIs/STIs. They refer clients to UHC for sterilization and management of complications. Service providers also distribute BCC materials from the clinic.

Box 5: Clinic Level Interventions

- Modification of existing service delivery protocol for the management of male RTI/STIs
- Ensuring privacy during service delivery
- Erection of billboard in front of HFWC
- Introduction of register for male clients
- Development of referral mechanisms

STI treatment

Male STI clients were encouraged to bring their partners to the clinic for treatment. Otherwise, service providers prescribed medicine for the partner on the client's prescription. Special attention was paid to counseling. Prescriptions were carefully written for purchase of medicines from the market if they were unavailable at the HFWC. Service providers treated male RTI/STI cases through syndromic management. Whenever possible the FWV or SACMO motivated female clients at the satellite clinics to refer their husbands to the HFWC for treatment. No clinic hours were allocated for the male clients as both male and female providers were offering services.

Promoting male services

A register was developed by NIPORT and distributed to all experimental facilities to record information about male clients and their purpose of visit, signs and symptoms of diseases, treatment received and detailed information on referral clients. The BCC materials were dis-



tributed from clinics by the FWVs and FWAs. Posters were placed inside and outside the clinics including service providers' rooms. A billboard was erected in front of each clinic mentioning the availability of male services.

Community Level

Information dissemination

Forty-eight group meetings were organized to inform community members about the availability of services for men at the HFWCs, to raise awareness of RTIs/STIs and the responsibility of men in RH. Male paramedics and field workers organized the meetings with local leaders, religious leaders, adult males and male adolescents. On an average, 25-30 people attended each meeting. The newly developed BCC materials were distributed in each community by the FWAs. Posters were placed in bazaars, clubs and other meeting places. Special attempts were made to inform the community members in two experimental HFWC areas. A loudspeaker was rented for a day and announcements were made about the availability of the male services from the selected HFWCs.

Box 6: Community Level Interventions

- Group meeting with local elites, male adults and adolescents organized by FPI, AHI and HAs
- Motivation of women at satellite clinics to send their husbands for treatment
- Distribution of BCC materials
- Loudspeaker announcements at community level

Monitoring and Supervision of the Project Activities

The program managers developed a comprehensive plan to monitor project activities. Each month they visited centers to oversee on-going project activities. During these visits, they observed each element of service delivery. A monitoring checklist for record keeping purposes was maintained. NIPORT and the Population Council team also visited each site and completed the monitoring form. During the visit, program managers provided technical assistance and helped service providers resolve pending issues.

Findings

Baseline Survey

Health care providers in rural Bangladesh comprise service providers and field workers. The former constitute MOs (MCH-FP), Senior FWVs, SACMOs and FWVs who deliver services at the clinics. The latter comprise HAs and FWAs who work at the community level. A total of 20 service providers and 75 field workers from the experimental areas while 9 service providers and 23 field workers were interviewed from the control areas in the baseline survey. The survey revealed:

- The age distribution of the service providers and field workers was almost the same in both experimental and control areas. The average age of the service providers and field workers was 39 years.
- The majority of service providers and field workers had received basic training. About one-third also received refresher training on health and family planning covering topics as diverse as FP methods, (ANC, PNC, menstrual regulation, childcare, infectious diseases, EPI, vitamin A and BCC). A few of them were also trained on RTI/STIs and HIV/AIDS.
- Knowledge on the cause of STIs was very low among the field workers and the service providers. Many held misconceptions about STIs. There was no major difference in knowledge about the transmission and prevention of STIs among service providers from both the experimental and control areas, and the majority of the service providers and field workers confused STIs with HIV/AIDS.
- Most service providers were either unclear or completely unaware of the health consequences of untreated STIs and RTIs. For example, about 60 percent revealed that death was one consequence of RTI/STIs (perhaps confusing it with HIV/AIDS). Yet service providers had a fairly good knowledge about the signs and symptoms of RTI/STIs. In addition, they were well informed about transmission and prevention of HIV/AIDS.
- The service providers and field workers were asked how comfortable they were discussing

sexual issues with clients. The majority reported positively. They were also asked to mention ways in which to involve males in reproductive health. Most felt strongly that men should be made aware of their role and responsibility.

Inventory Control

A complete inventory of equipment and supplies (including BCC materials) available at HFWCs was conducted prior to the intervention. Most of these inventoried items were available at the HFWCs. However, many were unused. Available equipment and supplies included Sims speculum, holding forceps, gali pot, instrument tray, gloves, torch light, cotton, lifter, autoclave, boiling pot, stove, bleaching powder, Dettol/Savlon and kerosene oil. Most of the service providers reported that recurrent items (Dettol/Savlon, cotton, kerosene, etc.) were frequently out of stock.

Views of Community and Religious Leaders about Male Involvement and HFWC Services

Seven focus group discussions were conducted in the intervention areas to gather opinions of the community and religious leaders about men's reproductive health issues and the integration of male services into the HFWCs.

Participants reported that:

- By and large they sought medical advice from the village doctor or *Kabiraj* or purchased medicines from the pharmacy without any prescriptions.
- HFWCs were perceived to be female and child health care centers.
- Existing clinic hours were convenient and did not suggest separate timings for men.
- Diarrhea, fever, jaundice and skin disease were the most common ailments in their locality.
- The common STIs known to them were gonorrhea and syphilis.
- They had heard about HIV/AIDS from the electronic media.
- They were aware that men and women suffer from sexually transmitted diseases and considered unprotected intercourse as the main cause of STIs.
- The disease burden was higher on men than women as they were more promiscuous.
- Most victims tried to hide the disease and sought treatment secretly from a *Kabiraj* or a doctor.



Misconceptions about Condom Use

The discussions also revealed that there were widespread misconceptions about family planning. The majority of informants believed that family planning was uniquely a woman's issue. Some considered condom use as a sin. One stated:

Let me tell you about my experience. I have been married for 10 years. I have five children. Allah keeps all of them in good health. I never used any contraceptive methods or any artificial methods. Using condoms means keeping the wife unsatisfied and unhappy. It is killing of children. Moreover, the discharge of semen somewhere else is a "Gunnah." It is wife's right (Haaqk). I cannot do it. She (my wife) may use some methods but I will not. It is her sin not mine.

Unsatisfactory Service Delivery

The quality of services from HFWCs led to exhaustive discussions. Every respondent mentioned that the services offered at HFWCs were unsatisfactory except in the case of prenatal, post-natal and family planning services. Shortages in medicines were a common complaint from the service providers.

Respondents suggested the use of billboards or posters in public places and community meetings and distribution of leaflets with key messages to improve utilization of HFWCs services among men. Announcements through a loudspeaker were regarded as effective. Involving local union council members and influential community members was viewed as a favorable strategy.



Lessons Learned

- The results from the study so far demonstrate that it is possible to introduce services for men into the HFWCs – men will come to the health center for male services and paramedics can provide appropriate levels of care.
- All levels of health care providers require training in men’s reproductive health care services, particularly STIs and HIV/AIDS issues. However, once they are trained these service providers can be considered as skilled and informed health care staff. Service providers can be trained to provide health care to men.
- Existing health care facilities can be used to provide health services to men.
- The preliminary results suggest that it is not necessary to change the timings of the HFWC’s services to accommodate men.
- Service providers and field workers need to be more proactive to adequately discuss sexuality issues.

References

Hussain, M. A., G. S. Rhaman and N. Begum. 1996. “A Study on Prevalence of RTI/STDs in a Rural Area of Bangladesh.” Dhaka, Bangladesh: Save the Children (USA).

Piet-Pelon, N. U. Rob and M. E. Khan. 1999. Male Involvement in Bangladesh, India and Pakistan: Reproductive Health Issues. Dhaka, Bangladesh: Karshaf Publishers.

Piet-Pelon, N. and U. Rob. 1997. Male Involvement in the Bangladesh Family Planning and Reproductive Health Program. *International Quarterly of Community Health Education*. Vol. 17 (2):195-206.

Population Council. 1996a. “Male Involvement: A Challenge for the Bangladesh National Family Planning Program.” Policy Dialogue No. 2. Dhaka, Bangladesh: Population Council.

Population Council. 1996b. “Integration of RTI Care into Existing Family Planning Services.” Policy Dialogue No. 3. Dhaka, Bangladesh: Population Council.

Directorate of Family Planning, NIPORT and Population Council. 1998. “Getting Men Involved in Family Planning: Experience from an Innovative Program.” Final Report. Asia & Near East Operations Research and Technical Assistance Project. Dhaka, Bangladesh: Population Council.

Wasserheit, J. N. et al. 1989. “Reproductive Tract Infection in a Family Planning Population in Rural Bangladesh,” *Studies in Family Planning* 20(2): 69-79.

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