"INVOLVING THE OTHER HALF"

Male perception of BRAC's health program

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ABSTRACT

In July 1991, BRAC integrated its diverse health activities into the newly established Women Health and Development Programme (WHDP). But as men play a key role in making decisions in deferent spheres of women's life, health programme managers increasingly recognize the importance of male involvement in women focused health program.

This study was therefore done with the objectives, to determine the knowledge, attitude and felt need of the male population of the community regarding BRAC's Women's Health and Development Program. The principal investigator stayed for nearly a month (Jan1996) with a family in a typical village of a WHDP working area to gather information. Informal conversation , key informant interview and observation of health care service delivery was done .

The study reveals that , men have a generalized feeling of being neglected by the BRAC's health program. Men have knowledge only about the curative components of the programme though more programmatic input was given to the preventive components. Contradictory attitude was revealed among men regarding BRAC's programme. This was also found that there is lack of regular male contact by the field workers. However, a strong felt need was expressed by most men regarding health information and services.

In order to ensure male involvement in the program, it was recommended to organize orientation session for field workers on male involvement, to strengthen male forums, to specify male audience, to open male only clinic and to recruit male community health workers.

INTRODUCTION

BRAC, the largest non- governmental organization in Bangladesh, uses an holistic approach towards helping the poorest of the poor in rural areas, with no collateral credit programme, income generating programme, education, training and health care. BRAC programmes cover some 55,000 villages in Bangladesh .

In July 1991, BRAC integrated its diverse health activities into the newly established Women's Health and Development Programme (WHDP). This new initiative offered integrated maternal and child health services in 10 thanas. The goals of WHDP were:

to improve the health and nutrition status of women and children, and

to develop and strengthen the capacity of communities to sustain health activities initiated by the program for achieving these goals.

WHDP facilitated the delivery of government services and also delivered some selective complementary services. WHDP trained village women as health workers, organized them into health education and promotion groups, mobilized the community for health and development activities.

Table 1.

The target population of WHDP by types of services:

Women	Children	Community
-Ante and postnatal care and management of high risk cases -Immunization -Family planning -Health and nutrition education -Safe delivery service -Neonatal care	-Colostrum and breast feeding -EPI -Appropriate weaning food -Growth monitoring -Pneumonia control	-TB treatment and control -Safe water and sanitation - Health and nutrition education

Table 1 clearly shows that BRAC's health programme is primarily focused on women and children. The obvious reason is that they are the most vulnerable and neglected segment of the society. In Bangladesh this group constitutes about 67.60 % of the population(1). Disease and ill health take the heaviest toll among these groups. The risk of maternal mortality is 150 times greater than in developed countries(1). In 1995, the maternal and infant mortality in Bangladesh were 4.6 and 77 per thousand live births(2). But women health is never entirely an women affair. In a male dominant traditional society like Bangladesh, women health is

dependent on the behavior of their male guardians. Low economic status of women also works against their ability to gain their partner's cooperation in their health behavior.

Moreover, studies show man's ignorance about women's health problems and needs. It is observed that in developing countries most men assign the responsibility of contraceptive use to women(3-6). As such, health programme managers worldwide increasingly recognize that marginalizing men is harmful to women's health. So, the question arises, how can men be more supportive and involved in women's health(7-9). The essential role men can share in the women's reproductive health was defined in International Conference on Population and Development held in Cairo in 1994. The emphasis of the international definition is on gender equality. As the document states, " Men play key role in bringing about gender equality since, in most societies , men exercise preponderant power in nearly every sphere of life , ranging from personal decision regarding the size of family to the policy and programme decision takes at all level of government"(10). In addition to male program concentrating on the promotion of gender equality in all aspects of life, the conference document suggests developing programmes with an objective "..... to encourage men to take responsibility for their sexual behavior and thus social and family roles."(10)

With this in mind BRAC's health programme has taken some steps to mobilize the 'other half' i.e. the males through various male forums. To understand how these steps are functioning and to find out better ways to involve men in the programme it is important to know how the 'other half' or male population of BRAC's working area perceived its women focused health programmes.

This study was therefore carried out to:

- determine the level of knowledge of the male population regarding components of BRAC's health programme;
- assess the attitude of the male population towards BRAC's health programme; and
- asses the felt need of the male population regarding BRAC's programme information and health services for them.

METHODOLOGY

This was an exploratory study based on qualitative research methods. Given the nature of the study it was best to live with a family in a village of BRAC's WHDP working area. The principal investigator, therefore, gathered information by staying with a family in a village of WHDP working area for 3 weeks in January 1996.

Village profile

The village is situated 15km north of Bogra town with a total population of 834(Male 429, female 405). There were 195 households (TG* 104, NTG** 94). At the time of data collection, there were 22 tubewells, 5 pacca latrines, and one madrasa in this village. BRAC's health programme started in this village since July 1991. After 6 months in January 1992, BRAC's Rural Development Program (RDP) and Non-Formal Primary Education Program (NFPE) also started their activities in the village. At present BRAC's health, credit and non-formal education programmes are simultaneously functioning in the village. Health programme hasintroduced all the components for women, children and the community as mentioned in the introductory chapter. The study population was adult married males of the village. The study sample was selected purposively.

The first week of staying in the village was mainly devoted to rapport building with the family with whom the principal investigator stayed and also to obtaining a preliminary idea about the village and to identify possible respondents. As the family was distantly related to the researcher, a considerable amount of support

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TG* is target group, the family having less then 50 decimal of land and a family member of which sells manual labor for at least 100 days in a year. The rest are NTG** or non-target group.

was obtained from them in this regard. After a week the researcher returned to the head office to share his experience with the senior researchers and to take their advice.

In the second phase, the principal investigator stayed in the village for two weeks for data collection. Eight key informants (TG 4, NTG 4) were selected and interviewed. Twenty five informal conversations (TG 15, NTG 10) were carried out with a cross section of people. Conversations took place in different venues like, tea stall, in front of a village shop, club room, on way to bazaar etc.

Time line* was also performed with some 6 selected persons(3 TG, 3 NTG).

A combined service delivery center** was observed. Due to continuos stay at the village it was possible to pay multiple visits to the same respondent and to explore his full range of ideas. An attempt was made to select respondents from different social and economic background and to cover both TG and NTG population. Background information about the respondents and the study village were collected from the programme documents available in WHDP area office.

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*Time line- This is a research tool where the respondent is asked to tell chronologically the events s/he considers important in their life in a specific period of time. For this study the time period was 1985-95.

**Combined service delivery centre- It is a centre organized by both govt. and BRAC workers, where antenatal care , growth monitoring of children and immunization are provided. It is held once in a month.

FINDINGS

Knowledge

The males were asked to tell whether they had heard of BRAC and whether BRAC worked in their village. Almost everyone had heard about BRAC and were aware that BRAC , worked in their village. But the respondents initially expressed the feeling that they were not the right person to give idea about BRAC, rather it was the domain of their wives.

One man said, *"Why do you talk with me about BRAC? I know nothing particular about its work. My wife can help you."*

Another men replied. *"BRAC people come and talk with women only. Once I asked a BRAC girl during a women's meeting, what they were talking about? She replied,'these are not for you, uncle'.*

However, when the discussion progressed all the respondents could mention about BRAC's credit , school and health activities in general. The male respondents were asked to describe what they knew about BRAC's health programmes. Some responses were spontaneous, some came after probing.

A typical spontaneous comment as expressed by a majority of the respondents was, *"BRAC has given training to a woman of our village, who treats certain diseases"*

They were asked to name the diseases treated by the trained women. The diseases mentioned were ; pneumonia ,tuberculosis, worm, fever. With probing the majority of the respondents could add two more health components; weighing of children and examination of pregnant women. Most of the men were confused and uncertain about these two components.

One man said, *"Every time my wife comes back from the weighing session and tells me that the baby has increased her weight such and such kg. I don't understand what is the use of knowing it."*

Special inquiry was made of the husbands of pregnant women to know their level of knowledge regarding antenatal care given by BRAC. It was found that they have a vague idea that some examinations were done in the antenatal care center but they did not know what these examinations were and what were the benefits of doing those.

Inquiry was also made to explore men's knowledge about Mahila shova* and Gram committee** . The majority of the male representatives could identify women's meeting in the village organized by BRAC, but they could not tell its function and responsibility. Most of the men thought that meetings with women were held for the distribution and recovery of loans. Nobody was found to be aware of the role of gram committee in identifying health problems.No significant difference in the level of knowledge was found between TG and NTG males .

Table 2

Men's knowledge about BRAC programme components:

	Present	Absent
Without probe	-Basic curative treatment -Pneumonia control -TB control	-Health and nutrition education -Community mobilization for EPI -Safe delivery service -Gram committee, Mahila shova
With probe	-Growth monitoring for children -Antenatal care	

*Mahila shova- To serve as an educational forum for topics related to health and nutrition, 20-25 women are grouped in a women's forum or mahila shova. One women from each household was selected to form the women 's forum in each village. This forum meets quarterly.

**Gram committee - To evolve the communities ability to identify and solve its own health and nutrition related problems. These gram committee were formed in each village comprising of 9-11 women with leadership qualities. The committee meets monthly to discuss their health problems and to find out possible solution.

Attitude

Different contradictory attitudes of male respondents were observed about BRAC programmes. The prevailing attitudes can be categorized in the following groups

Table 3

Male attitude towards BRAC programme:

Supporting attitude

"Nobody has given so much attention to the poor like BRAC before" A govt. servant, NTG

Opposing attitude

"BRAC activities are totally anti Islamic" A maulana, NTG

Confused attitude

" I am not sure but I think they are doing good works, because BRAC people are educated" A share cropper, TG
"BRAC activities apparently seem good but they might have some hidden intention" A small trader,TG

The table shows that males have their own points for supporting, opposing or confused attitudes. Those who have supporting attitudes mainly appreciated BRAC because of its attention to the poor. The main opposing argument of the respondents was that BRAC did not work in a Islamic way. They complained that BRAC did not maintain *purdah* for women, they did not teach Islam in their schools. Those who had a confused attitude seemed mostly not sure about BRAC's objectives. Some of them had an idea that BRAC had some hidden intention like competing in the national election.

An interesting finding in this regard was that, all the respondents who had a confused attitudes were members of the target group, while the majority of the respondents having either supporting or opposing attitude were members of nontarget group.

It was found further from the discussion that the opposing statements of the respondents were mainly targeted towards the credit and education programme of BRAC. There were no complaints about the health components.

As one of the most vocal among the anti-BRAC respondents stated,

"BRAC is polluting our village through anti-Islamic activities. They don't teach Islam in their schools, they don't maintain purdah *for women. These*

activities should be stopped. However, they are doing some good works for the health of our children and women, which I think can be continued"

When respondents were asked whether they have ever talked with any BRAC people or attended any meeting organized by BRAC, quite a good number of respondents presented their attitude as follows,

"I see BRAC people are coming and going with their motorcycles . They usually don't talk to me but they come to me only when they face any problem"

Respondents could not mention any regular male forum but they could remember some earlier problem oriented male meetings. It seems that instead of regular networking, occasional contact is made with men only when problem arise.

This assumption can be supported with a comment by a BRAC PO of WHDP, who said,

"We had to organize frequent male forums in the initial phase of the programme , when there were lots of opposition in the village. Now people have more or less accepted BRAC, so the frequency of male forum has also reduced."

An indifferent attitude was observed among males in a combined service delivery center. A few male members from the neighboring house were sitting near the combined service delivery center. They were smoking and gossiping during the

whole session. They seemed not concerned about what was happening around them. They were small traders. They usually went to bazaar in the evening , but had nothing particular to do in the morning. Lastly, when men were asked to tell some important events in time in the village within the last ten years, only one out of six men mentioned the commencement of BRAC activities, specifically the credit activity in the village, as one of the important events.

Felt need

It was revealed from the comments of the respondents that there is a strong felt need for health related information and services among the male population .One respondent said in disappointment that,

" Who is going to listen to our problems, Neither the government nor even the non-government organizations? "

One respondent who is a day laborer, disagreed with the rationale of providing health services to the doorsteps only for women and children. He said,

"It is right that we can go a far way to get our treatment, which a woman or a child can not but we lose the earning of that day too. "

The need for a contact person to discuss family planning matters was expressed by many respondents, such as,

"With whom should I talk about family planning? The female workers come and talk only with the females"

Equal necessity of health education for both men and women was demanded by many respondents . As one educated elite of the village said,

"Husband and wife are two eyes of a house. Both are blind in terms of health knowledge in this rural area . You are giving knowledge only to the wife, that means you are giving light to only one eye. That makes it a oneeyed house . If the other eye still remains blind the house will not function properly."

When they were asked, why they did not learn from their wives, the response was,

"Who is going to learn things from their wives?"

Felt need for health services for men was equally expressed by the TG and NTG men.

DISCUSSION

This study was carried out to explore the male perception of BRAC's health programme in terms of men's knowledge, attitude and felt need.

Knowledge

Initial comments made by the male population about BRAC's programme reflects the impression of an outsider, who thinks that he is not a part of the activity. This is valid to some extent because BRAC health programme is primarily not focused towards men. Yet the male population of the community were able to mention some of the components of the health programme.

However, the point of consideration here is that , male groups spontaneously mentioned the curative components of the programme, while they only mentioned

the preventive components after probing. The reason for spontaneous response regarding the curative components may be because, benefit from treating a disease is immediate and visible. Moreover, men also receive the benefits of the TB control programme . The components that they mentioned after probing were preventive in nature. Benefits from such components as growth monitoring and ante natal care is not immediate and not even clear to males . The reason they mentioned these components at all may be because, these services are given in a combined service delivery center held once a month, which is an important visible event in the village.

On the other hand, men failed to mention some components altogether, such as health education, community mobilization, and community capacity building. This may be because, information on these services are not targeted towards man, moreover there is neither any immediate benefit from these components nor the visibility of a crowded combined service delivery center.

It seems from the finding that in case of male groups, knowledge of components of the health programme depended on the immediate visible benefit of the components and the visibility of activities concerning the delivery of the components.

Attitude

A significant difference in attitude is evident in TG and NTG respondents. None of the NTG respondents were found to be confused about BRAC's programme, rather they showed either supporting or opposing attitude. This may be due to their social positions. As most of the NTG respondents were the decision makers in the village they cannot remain confused about any social issues and must take a stand. On the other hand, TG members depend greatly on the opinions of NTG. As NTG members are divided among themselves in their opinion, this might have influenced the TG members and made them confused about this issue. There might be other reasons too such as, TG members did not want to voice their opinions apprehending that this might interrupt the services their families were getting from BRAC. The TG males could have more knowledge from their wives but result shows poor spousal communication in this regard.

The importance of male involvement in the programme was is underestimated by the field workers. As a result there was a lack of proper networking by BRAC workers with the males through regular personal contact or male meetings. Rather

some occasional contacts were made with them only in problematic situations. Males were considered as problem solving agents. The intention behind communicating with men was more to neutralize and overcome the local opposition and to gain acceptance in the community rather then to educate males with effective programmatic information. As a result inadequate and incomplete knowledge about the program persists among the males and the programme was not transparent to them. Thus, the sense of belonging did not grow among the male section of the community. A missing link, therefore exists between the males and the programme. This was reflected in men's indifferent attitude at the combined service delivery center and also in the result of timeline, where they didn't consider commencement of BRAC activities as an important event in their village.

However, a positive point is that, there was little social and religious resistance against the health programme in the community. This may be because, health is not an area of power exercise, rather health is an innocent issue.

Felt need

It seems from the finding that men had a feeling of being neglected by health care providers . They were not even convinced with the logic that women and children alone should get services at their doorsteps. Men think, in spite of the advantage of their mobility, there is a wastage of their wage for the day which could be spent to get treatment from a distant place. This will ultimately affect their family.

Further, inadequate male participation in family planning is a crucial issue these days. Comments made by the respondents can throw a light on this problem. According to the respondents, they had no particular person or place to discuss family planning, the whole matter was encircled among the women. This reflects an obvious felt need for a separate place and person with whom men can discuss family planning or other related personal issues . The allegorical comment made by an educated respondent expresses the idea that husband and wife are both ignorant in that rural area, so both of them needed knowledge. Though, men's disdain for learning things from their wives reflects their male chauvinistic attitude. However, all these points suggest a strong felt need by both TG and NTG men in the community for health education about health and also health services for them at the village level.

CONCLUSION

Some strengths and weaknesses of BRAC's health programme were revealed from the findings.

Strengths.

1. Though BRAC's health programme is not targeted towards men, still every man of the village has a general idea about BRAC activities,

2. There is less social and religious resistance against BRAC's health programme than against its credit and education programmes, and

3. There is strong felt need among men for health information and services for them.

Weaknesses

1. Men think they are excluded from BRAC's health programme.

2. Men have inadequate and incomplete knowledge on different components of the health programme. As a result they have contradictory attitude towards the programme.

3. Not enough importance is given to the existing male forum. Male forum is conducted in problematic situation only and not on a regular basis.

4. The importance of male involvement in the programm is not properly understood by the field workers.

However, the findings of this study gives an insight to the male perception of BRAC's WHDP which might help BRAC and other NGOS in finding ways to involve men in women focused programs and to make this "other half" of the community be more supportive to the programme.

RECOMMENDATIONS

Based on the findings of this study the following recommendations are made to involve the males in BRAC's health programme-

1 . An orientation session for the field workers may be organized to discuss the importance of male involvement in the program.

2. Measures may be taken to strengthen regular contacts with the males rather than making occasional contact during problematic situations.

3. Some segmentation of the male audience may be done, like a forum for husbands of pregnant women or husbands of gram committee members. This would allow them to discuss matters of their own family interest.

4. The couple as a unite for knowledge dissemination may be considered.

5. 'Male only' forum may be organized for family planning counseling and ervice.

6. Ways should be explored to increase spousal communication.

7. Unemployed young men of the village can be trained to act as part time community health workers, to work specially with men.

REFERENCE

1. Rashid, Khabir, Hyder. Text Book of Community Medicine and Public Health, Second Edition, 1995.

2. Statistical Pocket Book of Bangladesh,1995. Bangladesh Bureau of Statistics, Statistic al Division, Ministry of Planning, Dhaka .

3. Ziauddin ,S. M. Women health and illness ; perception of men and women in the rural area of Bangladesh: BRAC health studies 1993 Vol X .

4. Okojie CE. Gender inequalities of health in third world: Social Science and medicine, 1994 Nov .39 (9).

5. Conveying concerns: Women write on male participation in the family. International program: Population reference bureau, USA, 1995 Jul.

6. Final Report: Workshop on male participation in family planning, Lahore. Pakistan. 1993.

7. Men and Family planning: Network, Family Health In ternational 1992 Aug. Vol 13, No 1. 8. Male involvement in family planning: Program initiatives. International planned Parenthood federation (IPPF)U.K, 1984 .

9. Danforth N ; Jezowski T. Beyond Cairo. Men , Family Planning and Reproductive Health (Unpublished): Presented at the 122nd Annual meeting of

American Public Health Association (APHA) Washington DC 1994 Oct, No-3 (5)P.

10. Nancy J. Poet - Pelon, Khabir AA. Highlights of Regional male involvement family Planning program: Draft paper presented at the workshop on male involvement in family planning, Dhaka 1996. Jointly organized by NIPORT, GTZ, AVSC and the Population Council.

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