Invisible Men in Family Planning: Determinants of Men's Unmet Need in Bangladesh

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INVISIBLE MEN IN FAMILY PLANNING: DETERMINANTS OF MEN'S UNMET NEED IN BANGLADESH

by

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A Thesis Submitted to the Faculties
of Old Dominion University and Norfolk State University
in Partial Fulfillment of the Requirement for the Degree of

MASTER OF ARTS

APPLIED SOCIOLOGY

OLD DOMINION UNIVERSITY AND NORFOLK STATE UNIVERSITY
May 2002

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ABSTRACT

INVISIBLE MEN IN FAMILY PLANNING: DETERMINANTS OF MEN'S UNMET NEED IN BANGLADESH

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Old Dominion University and Norfolk State University, 2002
Director: Dr. Xiushi Yang

The prevalence of unmet need for family planning is a primary justification for family planning programs, but the prevalence of men’s unmet need for family planning and causes of unmet need have not been much explored. This study introduces the concept of men’s unmet need for family planning. Using the data from Bangladesh Demographic and Health Survey of 1996-97, this study examined the effect of some important correlates (age, socio-economic status, availability of the family planning services, and knowledge about contraceptive methods) on the unmet need for family planning. This study was designed to address the research questions: Do individual characteristics affect men’s unmet need for family planning? Does availability of the family planning services affect men’s unmet need for family planning? Does knowledge about contraceptive methods affect men’s unmet need for family planning?

Analyses revealed some important findings. First, individual characteristic (number of children) and availability of the family planning services (visits of family planning workers and methods discussed with family planning workers) affect men’s unmet need for family planning at multivariate level in the first model. The model explains 6 percent of variation in having unmet need for family planning. However, individual characteristics, availability of the family planning services, and knowledge about contraceptive methods have significant effects on men’s unmet need for family
planning at bivariate level. Second, age is the only significant correlates that affect men’s unmet need for family planning in the second model. The second model explains 27 percent of the variation of having unmet need for family planning. Implication and direction for future research are also discussed.
This thesis is dedicated to my brother Dr. Niamul Kabir.
ACKNOWLEDGEMENTS

This piece of research is a sequel of co-operation from each and every corner. First of all, I avail the opportunity of tranquilizing my soul by rendering my deepest gratitude to Dr. Xiushi Yang, my honorable research supervisor, who created zeal in me for such a long way to traverse. Dr. Yang, being my mentor, with his versatile knowledge and dynamic attitude, assisted, guided and instructed me in every aspect of this research.

I also feel urgency in expressing my thanks to Dr. Randy R. Gainey. Without his support, suggestions and great eye for detail I would not have been able to complete this project. He aided me very much in constructing my ‘theoretical framework’ and in explaining results of the study. He always smiles and never says “no” to me.

I would like to thank Dr. William K. Agyei. I know you had a busy schedule, and I appreciate your time and comments, which assisted me in completing thesis.

Dr. Ivan Sun and Dr. Garland White also extended their warm hands of co-operation by giving assistance for data analysis and thesis proposal.

I admit profound help of Mr. Shahidul Islam for his active co-operation throughout the whole process. His help demands special recognition.

I remember Jessica Huffman and Rebecca Grove for their thoughtful comments. You are the best friends anyone could have in a foreign country.
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CHAPTER I
INTRODUCTION

STATEMENT OF THE PROBLEM

Unmet need for family planning has become a common phenomenon in developing countries over the past decade. In general, unmet need can be defined as the gap between a person’s reproductive intention and actual contraceptive behavior (Casterline and Sinding 2000). The concept received little attention among demographers before the 1960s. Along with the awareness of the importance of population control in the 1960s and 1970s, more research efforts have been devoted to examining many aspects of family planning including unmet need (Ngom 1997). While previous research has identified the prevalence of unmet need among women in developing countries, the same issue for men has largely been ignored. This research attempts to identify the determinants of unmet need among men in a developing country, Bangladesh.

In spite of considerable evidence that a husband’s desires or intentions influence a couple’s contraceptive practice, fertility research continues to be based primarily on the views of women. Since men continue to have more power than woman, we might have expected husband’s desires to have greater influence than wives’ desires on couple’s outcome (Thompson 1997). In traditional societies, women have a dependent and inferior status, eventually it generates two outcomes: either, woman’s opinions are influenced strongly by their husband’s opinion or, wives who have independent opinions

The format of this thesis follows current style requirements of the American Sociological Review.
may but are afraid to voice them (Mason and Smith 2000). For countries like Bangladesh, the picture is even worse. A man is, here, considered the breadwinner of the family. Since the man is responsible for the maintenance of the family, according to the patriarchal system, he controls the income and assets of the household and can restrict women from using contraceptives (Ahmad 1991).

It could be said that a woman’s contraceptive attitude depends not only on her individual characteristics but also on the characteristics of her husband. The need to target and involve men equally in family planning programs cannot be overemphasized. It is evident from the results of studies (Ahmad 1991; Ezeh 1993; Thompson 1997; and Mason and Smith 2000) that a programs that targets men as a means for reaching and altering their wives’ contraceptive behavior will fare much better than ones targeting women as a means of reaching their husbands. As men being largely ignored in the family planning program, his unmet need also remains unanalyzed.

The concept of ‘unmet need’ was first identified from the findings of the contraceptive knowledge, attitude and practice surveys (Johns Hopkins University Population Information Program 1996). This concept was modified by researchers, as it became a central area of research in family planning. The term “KAP (Knowledge, Attitude and Practice) -Gap” was popular in earlier days to address unmet needs. Freedman and colleagues first pointed out “KAP-Gap” among women and described the status of those women as “discrepant behavior” (Freedman, Coombs, Chang 1972; Freedman and Coombs 1974). Bruce Stokes introduced the term of unmet need in the literature in 1977. Later, in his study of five Asian countries, Westoff (1978) replaced the term “KAP-Gap” with “Unmet Need” as an indication of the discrepancy between
fertility preferences and contraceptive use. Westoff excluded pregnant, and amenorrheic women on the ground that they had no immediate need for contraception (Casterline and Sinding 2000).

As soon as unmet need was estimated empirically following a conventional definition, it has been criticized heavily by the academicians. Nortman (1982) argued that some pregnant women, breastfeeding, and amenorrheic women should be included in the definition of unmet need because many would require contraception as soon as their current status ended. Along this line, the Demographic and Health Surveys measured the concept by including questions on intentional pregnancies, mistimed and unwanted pregnancies and the pattern of contraception at the time of conception (Casterline and Sinding 2000). At the International Conference on Population and Development, Steven Sinding and Mahmoud Fathalla suggested that persons who are dissatisfied with contraceptive methods be included. Since then, the concept of unmet need has been modified by researchers (John Hopkins University Population Information Program 1996).

Although progress has been made, the concept of “unmet need”, still remains incomplete since men’s unmet needs are often ignored in the conceptualization. Family planning programs have drawn attention away from men’s unmet need over the past decades (Balswick 1972). Men are absolutely visible in every aspects of life. They dominate whatever decision has been taken by women in developing countries. These men really become invisible when the question of using contraceptives comes up. While some researchers have argued that if there is a good communication between husbands and wives, unmet need could be measured from wives’ reports. Others suggest that it is
the time for research community to pay more attention to men's unmet need (Stokes 1980). They argued that without examining men's unmet needs, policy makers couldn't get the desired information on men's demand for family planning (Ngom 1997).

Although conception involves two people, society often ignores men's involvement in family planning. In Bangladesh, for example, male contraceptives are considered secondary choice to combat population problems. Moreover, men tend to believe that since female contraceptives are so widely available they do not need to use any contraceptive method. This has become the main excuse for men not using any contraceptives (Stokes 1980). In most cases men's attitudes determines women's attitudes toward birth control in general and contraceptives in particular (Ngom 1997). If men have more things to say about fertility reduction than female, fertility transition would depend as much on the fertility preferences of men as that of women (Dodoo, Luo, Panayotova 1997).

Most importantly, few organized family planning programs target men as clients. Family planning program efforts and methods tend to focus on women, because men do not feel comfortable and welcome in family planning clinics. As men still dominate family decisions in Bangladesh, the ultimate success of family planning program in developing countries may rest on the availability and the use of effective male contraceptives and the involvement of men in family planning programs (Stokes 1980). The success achieved so far in the national family planning program in Bangladesh is encouraging, but several issues remain that are of concern such as the need for men to participate more actively in family planning acceptance, the need for quality services and lack of steady supply of contraceptives from external sources. Along with this, men's
unmet need for family planning remains largely unexplored by researchers in Bangladesh. An attempt has been made in this research to fill this gap in research as well as try to identify the determinants of men’s unmet need for family planning in Bangladesh.

THE RESEARCH SETTING

Bangladesh, a predominantly Muslim and rural country, is confronted with serious handicaps of social and economic underdevelopment. The economy is based on largely premodern techniques of production. A large segment of the population lives close to the margin of life, and the country is frequently struck by natural disasters such as cyclones, tidal bores and devastating floods (Duza 1990). At the same time, Bangladesh was among the first Asian countries to recognize the need to reduce rates of population growth, and for the last 20 years, this recognition has been an important element in the country’s development planning (Amin and Choudhuri 1987). Bangladesh has not set records for the fastest increase in contraceptive use, the swiftest fertility decline or the most substantial drop in desired family size, but between 1975 and 1989, contraceptive prevalence rose steadily and the total fertility rate declined. These accomplishments are remarkable, particularly for one of the world’s poorest nations (Larson and Mitra 1992).

STATEMENT OF THE RESEARCH QUESTION

Women are the main focus of interest among the policy makers of population control in Bangladesh. Several studies have been conducted on the unmet need for family
planning in Bangladesh (Khuda and Howlader 1986; Khuda and Howlader 1988; Westoff and Pebley 1981; and Sabir and Ali 1993). Findings from those studies indicate that the extent of unmet need in Bangladesh was very high, although it is decreasing. Overall, 16 percent of women have unmet need for family planning services. In the broadest sense, research on unmet need is inadequate in Bangladesh. Moreover, the limited research deals with the extent of the unmet need; it's regional variation and variations along with other social and demographic characteristics among women. No systemic research in general and sociological research in particular has been conducted on the determinants of men's unmet need for family planning in Bangladesh. Availability of the family planning services, knowledge about contraceptive methods, and demographic variables (i.e., age, number of children) remain ignored by researchers. This study aims to fill at least partially this gap by investigating the determinants of men's unmet need for family planning in Bangladesh.

Based on the above discussion this study is designed to answer the following research questions:

1. Do individual characteristics affect men’s unmet need for family planning?

2. Does availability of family planning service affect men’s unmet need for family planning?

3. Does knowledge about contraceptive methods affect men’s unmet need for family planning?
PLAN OF THE STUDY

This study will investigate the effect of individual characteristics, socio-economic status, availability of the family planning services, and knowledge about contraceptive methods on men’s unmet need for family planning in Bangladesh. Data used in this study come from the Bangladesh Demographic and Health Survey, 1996-97. The sample includes 3284 currently married men age 15-60+. At the univariate level, socio-economic and demographic characteristics will be presented. At the bivariate level, cross-tabulation will be used to examine the association between men’s unmet need and individual characteristics, socio-economic status, availability of the family planning services, and knowledge about contraceptive methods. Further, logistic regression analysis will be performed to identify the determinants of men’s unmet need for family planning in Bangladesh.

VALUE OF THE STUDY

This study will partially fill the existing research gap on men’s unmet need in Bangladesh by investigating the determinants of men’s unmet need for family planning. Since the total demand for family planning cannot be measured if we don’t get the available information for both men’s and women’s unmet need for family planning, this study will bring new insights on unmet need for family planning by taking into account men’s unmet need for family planning. This research will identify the determinants of men’s unmet need for family planning, which in turn helps policy makers to emphasize certain issues or to bring some changes in family planning program that would enhance the existing conditions about men’s unmet need. As we know, several studies have been
conducted on women’s unmet need and these studies directed our attention to possible factors that affect women’s unmet need. The results of this study would allow researchers to compare the different determinants of men’s and women’s unmet need for family planning in Bangladesh.
Unmet need cannot be explained in terms of demographic variables alone; it needs to be looked in conjunction with the individual characteristics and the demographic characteristics of potential clientele. However, most research that has been done on unmet need is narrow in focus and highly concentrated on measurement issues. Moreover, no issues have been raised about men’s unmet need. In this study I will examine whether any relationship exists between men’s unmet need and important variables like socio-economic status, age, number of living children, availability of the family planning services, and knowledge about contraceptive methods. No research has been tapped into these variables, which might play an important role in formulating policies to address the unmet need for family planning.

This literature review chapter consists of seven sections. The first section of the review discusses the definition of unmet need for family planning and measurement issues. The second section examines characteristics of family planning programs with a particular focus on the availability of the family planning services. The third section describes knowledge about contraceptive methods and the fourth section depicts some individual and demographic characteristics related to unmet need. The fifth section describes current state of research on unmet need for family planning in Bangladesh. The sixth section covers the theoretical aspects on unmet need for family planning. The last section describes the hypotheses of the study.
UNMET NEED FOR FAMILY PLANNING

Unmet need is now an often-cited issue among demographers. However, there is no consensus on the definition of "unmet need". Casterline and Sinding, for example, define unmet need as "Conditions of wanting to avoid or postpone childbearing but not using any method of contraception" (2000:691). This definition, however, fails to take into account of spacers (want to delay their next pregnancy) and limiters (want to stop giving birth of children). Westoff and Ochoa (1991) propose a definition of unmet need for family planning by including spacers and limiters. According to them,

"At any given time in a population, there are some women or couples who are not using contraception but who wish to control their fertility-either to postpone the next wanted birth or to prevent unwanted childbearing after having achieved the desired number of children" (1991:2).

Further refinements of the definition of unmet need for family planning are subsequently made by Westoff and Pebley (1981) and by Nortman (1982). Westoff and Pebley (1981) present estimates of unmet need based on eleven possible measures representing composites of four criteria (fertility motives, pregnancy status, breastfeeding, and effectiveness of contraception) in addition to the desire for no more children. Nortman's study included all women regardless of their pregnancy and breastfeeding status to accommodate both current and subsequent contraceptive need (Tsui 1985).

Unmet need for family planning also varies in terms of operational measurement. Researchers are still looking for one unique measurement for unmet need. Some measures identify 40 percent unmet need for one country and by using the other measure it shows 7 percent unmet need for that country. As mentioned by Westoff (1978), measures must follow the level of family planning program. However, all the research
that has been done on unmet need for family planning basically describes the trends, in
some cases determinants and cross-cultural variation.

The first study was done by Westoff in 1978. He stated that unmet need did not
vary widely, and the demand for family planning service was quite constant across
Korea, Malaysia, Nepal, Pakistan and Thailand. He revealed that this pattern resulted
from the interacting and offsetting movement of fertility intentions and fertility control.
However, he did not pay attention to how to deal with pregnant and amenorrheic women
whose pregnancy was not intentional (Westoff 1978). Later, Westoff did another study on
unmet need. This time he included both pregnant and amenorrheic women in his model.
He found that unmet need was widespread among the limiters rather than the spacers in
all countries (e.g., Brazil, Colombia, Ecuador and Peru), with the only exception being
the Dominican Republic (Westoff 1988). This result is supported by Nortman’s study
(1982). However, Nortman included women who were breastfeeding their babies in her
analysis. Although birth spacing constitutes a sizable proportion of unmet need, on
average 43 percent spacer women have unmet need for family planning. She also divided
women into groups of younger and older ages and tried to see which group had the most
unmet need. She concluded that although contraceptive rate was high in those countries,
still a sizable market was unexplored by the family planning program, which should be
taken care of (Nortman 1982). The same result is also found in a study conducted in Sri
Lanka (DeGraff and Silva 1991).

In contrast to these studies, Bracket (1978) found that contraceptive use rate was
not high in the Dominican Republic, Costa Rica, Panama and Colombia. It could be
increased if the family planning program services were available and accessible to
clientele and if sterilization would be provided more widely and freely. The question is, what would be the priority for meeting the demand for family planning, i.e., unmet need.

Globally, 17 percent of women have unmet need for family planning. In order to deal with this pattern of unmet need, contraceptive prevalence rate has to increase by 15 percent, which is an overly ambitious goal. Because by that time, the number of women of reproductive age will also increase and that task would be more difficult. However, only looking at the unmet need for family planning cannot assure that it will improve satisfaction of clientele and will help to lower the fertility rate. The one conclusion must be made in this context is that the expansion of family planning services should be encouraged so that it could reach the unserved clientele (Sinding, Ross and Rosenfield 1994).

AVAILABILITY OF SERVICES

It is generally taken for granted that in developing countries, the availability of the family planning services would be the potential factor for explaining the unmet need for family planning. Through quality service women obtain the proper information, proper methods to be used, and also the services they need for possible side effects. Moreover, the supply should be in a continuous flow to increase the prevalence of the contraceptive method, which in turn helps to lower the unmet need for family planning. Women are willing to go to distant places if better service is not available near home. This pattern has been shown in Ghana, Peru, and Nigeria. The closest service-delivery point is not used by 39 percent of Nigerian, 25 percent of Peruvian, and 51 percent of Ghanaian. Clients tend to travel farther to get better services (Bongaarts and Bruce 1995).
To improve the quality of service, providers’ ability to discuss with clients effectively has also been given attention to by researchers. The performance of providers is also taken care of by some family planning programs. Because of that a study had compared work performance of trained workers and untrained workers (Kim, Rimon, Winnard, Corso, Mako, Lawal, Babalola, and Huntington 1992). It was found that the trained workers listened carefully, showed more patience, made clients more comfortable, and gave more details about the contraceptive methods. They were more careful in demonstrating how to use the contraceptive methods and in distributing brochure to the clients. The study also showed that good services made people more likely to seek clinics earlier for problems they might face while using particular contraceptive method. The counseling service also helped them to adopt a new method if they have faced problems with a current method, which helps to build a stronger base for long-term contraceptive use. The more the clients continued the first method, the better services the clients received from the clinics they need (Huezo and Malhotra 1993). Huezo and Malhotra suggested that services must be as comprehensive as possible so that they could close the gap between knowledge, intention and use.

In contrast, one study revealed that service quality is not as important for addressing unmet needs for family planning as that of costs of contraceptive use. The remoteness of the family planning services might be more powerful to explain unmet need rather than the quality of the family planning services (Casterline and Sinding 2000). Similar arguments were also found in studies conducted in South Korea and India (Devi, Rastogi, and Ratherford 1996).
Another argument came from the perspective of people's satisfaction. Satisfying people's various contraceptive needs requires a range of contraceptive methods. The more people get the contraceptive from family planning programs, the lower the level of unmet need of family planning. Sometimes, the expectation of poor quality of service also produces unmet need. It has been revealed that the home delivery of contraceptive methods by family planning workers has increased the prevalence rate of contraceptive methods (Johns Hopkins University Population Information Program 1996).

It is evident that both good quality and accessibility are important for family planning services in meeting the demand for services. However, access to a desired method is one of the six important elements of good-quality family planning services. The others are to encourage wider commercial sales, to start or expand social marketing programs, to train providers how to counsel empathetically, to provide privacy of clients and to reduce clients' waiting time and paperwork (Cornelius 1986). Unfortunately, at least 19 countries worldwide do not have any access to the oral pill, and 30 countries have no access to the intrauterine device (IUD). Female sterilization is not available in 37 countries, and vasectomy is not available in 61 countries. Except for China, in almost half of those countries women have access to only one or two contraceptive methods. Even if the services are available, some women still do not have access to contraceptives (Mauldin and Ross 1991).

KNOWLEDGE ABOUT CONTRACEPTIVES

Lack of knowledge is another determinant of the unmet need for family planning. It is measured by several indicators, mostly by whether the women or men have ever
heard about the methods or whether they have any idea about certain contraceptive methods or if they have any idea about contraceptives, and whether they have known where to get them. This can be referred to as conventional knowledge. However, it is difficult to say what would be the perfect indicator of knowledge about contraceptive methods. Knowledge varies from person to person and culture to culture. In some cases, it is described that women or men have knowledge if they could tell how to use the methods, what are the main side effects, and where they can get the methods.

Moreover, knowledge about contraceptive methods is also alternatively discussed as having spontaneous knowledge or not. This knowledge is measured as whether the couple knew about any method that can delay pregnancy or avoid pregnancy. As we know, one of the indicators is the source of methods. This knowledge is basically measured by asking female respondents where she could get the method they wanted to use, based on if they recognized any methods. Knowledge of side effects is mainly focused on the main problems of a method. Conventional knowledge includes only knowledge about any method; it does not include knowledge about source of method, and knowledge about side effects which spontaneous knowledge does. Yet it is hard to measure since most women hardly ever had concrete information about each method.

Conventional knowledge about contraceptives is very high in some countries such as Colombia, Costa Rica, Panama and Dominican Republic. Ninety-five percent of women in those countries knew at least one method and more importantly, at least one method was familiar to all women. However, familiarity differs in terms of contraceptive methods. Knowledge about the pill is almost universal. IUD is also widely known. Male sterilization is not a commonly known method, but Costa Rica showed the highest
percentage of knowledge about male sterilization. Most interestingly, traditional methods (withdrawal, periodic abstinence, and safe periods) are not widely known (Bracket 1978). A significant relationship has been found between knowledge about contraceptive methods and education in Nepal, Pakistan, Korea, Thailand, and Malaysia (Westoff 1978).

Although conventional knowledge about contraceptive methods is largely universal (Bracket 1978), spontaneous knowledge varied from nation to nation. The existence of spontaneous knowledge varied from 10 percent to 98 percent in Colombia, Dominican Republic, Ecuador, Egypt, Guatemala, Thailand, Togo, Tunisia, Uganda, and Zimbabwe. Name recognition of contraceptive method ranged from 29 to 99 percent among the women of these countries. Those able to correctly identify various methods varied widely ranging from 23 to 99 percent. Knowledge about side effect also varied. The opinion on side effects also dispersedly distributed. The four indicators were strongly correlated and the countries identified as having high or low levels of knowledge were similar regardless of which indicators was used (Bongaarts and Bruce 1995). However, it was found from their study that women, who have less knowledge about contraceptive methods, have greater unmet need compared to women who have better knowledge about contraceptive methods.

Some argued that knowledge about contraceptive methods could be measured by including the knowledge of financial costs of a method. According to Casterline and colleagues, women have to have knowledge about contraceptive methods, how to get the contraceptives, and the costs of contraceptive methods. They mentioned that the issue of uncertainty related to how to use the contraceptive methods further impeded the use of a
method. In the same way, lack of knowledge about side effects discouraged women from using contraceptives. The study conducted by Casterline and colleagues also revealed that since knowledge about contraceptive methods is universal, this factor does not necessarily explain the unmet need for family planning (Casterline, Perez, and Biddlecom 1997).

DEMOGRAPHICS

Studies have shown that unmet need has close links with individuals' socio-economic status and demographic variables such as age and number of children. Age is typically related to the unmet need for family planning. As age increases, until 35-39, the unmet need for family planning increases but it decreases after 39. This trend is common in Indonesia, Costa Rica, and Kenya. However, Bangladesh and Pakistan are different. The unmet need declines in both countries at a later age, after 45-49 years. All other Asian countries fall between these two categories (Westoff and Pebley 1981). The result is supported by Bracket's (1978) and Nortman's (1982) study. However, among young women, they have a demand for contraceptives to space the birth, which is just the opposite for older women. Older women are more prone to limit births than to space births. Interestingly, the unmet need became higher after giving birth within one-year period for both older and younger women (Nortman 1982).

In general, education is associated with the acceptance of new ideas. Women are no exception in this regard. Unmet need decreases as education increases. Westoff (1988) indicated that age and education are negatively associated with unmet need for family planning. However, he found that there was an inverse association between age and
unmet need for spacers but a positive association for the limiters. The former relationship is much stronger than the latter. This result is true in Colombia, Peru, Dominican Republic, Brazil, and Ecuador. While education is a good predictor of contraceptive use, it also affects unmet need (Westoff 1988). Later, Westoff and Bankole’s (1995) analysis of data from 27 countries between 1990-94 revealed that education was related to two types of unmet need for family planning. Some countries like Turkey do show that the higher the education, the lower the unmet need for family planning. This was not the case in other countries. In Sub-Saharan African countries, for example, unmet need was higher for all women regardless of the level of education.

Number of children is also a potential variable for explaining contraceptive use pattern, demand for contraceptives, and the extent of contraceptive use. A general pattern is that newly married women in developing countries want children soon after their marriage. This indicates that the unmet need is a non-existing phenomenon for these women. As soon as they gave birth to their first child, the unmet need for spacing declines sharply with each additional child. It is often found that every additional child brings successive changes in the unmet need for family planning. In some countries, the unmet need was high among women having more than two children. At the same time, intention to limit birth has increased as the number of children increased (Westoff and Bankole 1995; Westoff and Ochoa 1991). DeGraff and Silva (1991) concluded that if modern temporary methods could be provided by the family planning services they must have positive effects on spacers who have one child with unmet need for family planning.
CURRENT RESEARCH ON UNMET NEED

Westoff and Pebley did the first study on unmet need for family planning in Bangladesh in 1981. They revealed that Bangladesh had 22.9 percent unmet need for family planning (defined as desired number of children). However, they left pregnant women out of the analysis and it might be possible that a woman is pregnant but her pregnancy is not intentional. She might have the unmet need for family planning at the time of her pregnancy. This might cause under enumeration of the unmet need for family planning (Westoff and Pebley 1981).

A later study (Sabir and Ali 1993) has taken into account this limitation of the Westoff and Pebley study. The objectives of this study was to see the level of unmet need for family planning in Bangladesh and the fertility level if couples got their expected contraceptive methods without any further changes in the demand for children. Both researchers suggested that pregnant and amenorrheic women need serious attention for meeting the demand of contraceptives. The unmet need was higher among urban women than rural women. However, place of residence and age did not necessarily affect the unmet need for family planning. The results also suggested that fertility, measured in total fertility rate, would drop to 3.2 if all limiters could start to use some form of contraceptive. It will further decline to 3.0 if all women who want to postpone their next child for at least 5 years start using contraceptives. However, they made an important contribution by saying that the quality of field worker’s visits and services in the Family Welfare Clinics should receive more attention (Sabir and Ali 1993). What they left unanalyzed is whether women knew all the information about using contraceptives. However, the unmet need would be quite high if we include all currently married women
under 50 years and those who did not want any children and not using any contraceptive methods.

Khuda and Howlader (1986) found that unmet need was quite high in Bangladesh. Later, they did another study that included age, number of children, education, place of residence, employment status, and possession of land. As expected, they found positive relationships between age and number of children on one hand and the unmet need on the other. As age and number of children increases, unmet need also increases among the women. The unmet need was lower in urban areas than rural areas. It was higher among non-working women. Education was positively related to the unmet need for family planning for all age groups. Field workers' visitation had a tremendous impact on the unmet need for family planning. Future intention was also related to the unmet need. If women have future intention to use contraceptives, their unmet need is relatively lower (Khuda and Howlader 1988). No indication is given to whether women knew, adequately or not, about the different contraceptive methods, no distinctions was made between spacers and limiters.

Kantner and Bairagi (1996) have shown that the unmet need for spacing is higher among women who were 15-24 years of age. Limiting was prevalent among the older women who were looking for permanent or semi-permanent methods. However, this study did not include any variables, which are more likely to be related to the unmet need. Indeed studies reviewed above contribute a great deal to research dealing with the unmet need for family planning. But none of the existing studies paid any attention to men's unmet need for family planning, and thereby failed to capture the total demand for family planning. Existing studies have not placed enough emphasis upon service issues,
and individual and demographic characteristics. This research aims at incorporating these variables to identify the determinants of men’s unmet need for family planning in Bangladesh.

THEORETICAL FRAMEWORK

Some general progress has been made in the theoretical analysis of the unmet need for family planning but it is generally underdeveloped. There is still a controversy about measurement of unmet need. Some basic research has been done on critical conceptual issues, which might help to address the theoretical issues of the unmet need for family planning.

It is often viewed that fertility regulation is the responsibility of women, at the same time whether a woman should use contraceptives or not is highly influenced by men. Although men have expressed that they should have taken the responsibility of using contraceptives, it is rarely practiced in the male-dominated society (Stokes 1980). Aside from the responsibility, male contraceptive methods are not as popular as female contraceptive methods. The whole idea of fertility regulation is very much feminine.

Since the analysis of men’s unmet need still remains unexplored, we can borrow from the literature on women some concepts potentially useful for studying men’s unmet need as well. However, men’s contraceptive methods do not usually pose as much side effects as those for women. For this is the reason health concerns are not included in the present analysis.

The micro-level theoretical framework addressed in this section, which is schematically presented in Figure 1, focuses on age, number of children, socio-economic
status, availability of the family planning services and knowledge about contraceptive methods.

The magnitude of unmet need for family planning varies not only across countries, but also within countries. It is associated with stages in life cycle that are demarcated by age and by number of children. At the micro level, age refers to the current age in years. Almost everywhere, clear relationships emerge between women’s age and the level of unmet need when unmet need is divided into spacing and limiting components. Most unmet need among younger women is related to spacing for births.

Figure 1. Theoretical Framework for Determinants of Men’s Unmet Need for Family Planning in Bangladesh, 1996-97
because younger women still want to have more children. Among older women, most unmet need is for limiting birth because older women have had as many children as they want, and often more. Unmet need for limiting typically peaks among women in their late thirties or early forties and then declines in the (45-49) age group (Westoff and Ochoa 1991; Westoff and Bankole 1995). It could be inferred from this that men will also offer similar reasoning for limiting birth or spacing birth as their age increases.

The number of children follows exactly the same pattern as age: women who are in the early stages of family formation are more in need of family planning for spacing purposes than women with larger families who, in turn, are focused more on limiting fertility. The same rationale is assumed to work for men in Bangladesh. In developing countries, almost all married women and men want to have children and they want them soon after their marriage. Thus among childless married couples there is almost no unmet need for spacing or limiting births. Once couples have had their first child, however, unmet need for spacing in some countries decreases with each additional child, while in other countries it peaks after the birth of two children, and then decreases with each additional child. In almost all countries the unmet need for limiting births increases with each additional child (Westoff and Ochoa 1991; Westoff and Bankole 1995).

This might differ between rich people and poor people. The expectation for children is different for people in different strata. Wealthy people are more likely to have fewer children than are poor people, who view more children as a strength that would lead to greater prosperity for the household. This view is conventional among poor families in Bangladesh. This in turn indicates less pressure for using contraceptives.
Unmet need also varies with position in the social structure, i.e., socio-economic status, indicated here by education and occupation. In all but sub-Saharan African countries, unmet need declines with increasing levels of education; it is highest among women with no formal education (Westoff and Ochoa 1991). Among the factors determining unmet need for family planning, education appears to be the most significant one; education is positively associated with the unmet need for family planning.

Evidence suggests that education not only increases awareness of social mobility and creates a new outlook and rationalism among couples, but also reduces desired family size by raising desired living standards, bringing about a better understanding of the reproductive process, better knowledge about health care and access to modern and effective means of birth control, hence decreasing the unmet need for family planning (Islam and Mahmud 1995). Simply, education reduces the demand for children and thus increases the desire, and the ability to regulate fertility (Singh and Casterline 1985).

The emergence of non-agricultural employment opportunities for men has had a substantial impact on the unmet need for family planning. While this has probably been true for those men who have participated in those occupations, which are associated with low birth rates, and low unmet need for family planning (Repetto 1979). For one thing, there is evidence that not only occupation is related to unmet need for family planning, but also to the worker’s status within occupations. It is mainly for the men who are regular employees outside the household who show low unmet need for family planning. By and large, the unmet need for family planning of family workers are the same as those who are not economically active (Lee and Cho 1976). Apart from any effect that employment has on unmet need, improvement in the occupational structure of men is
desirable because of the other changes it brings in their status. However, it is also possible that both occupation and unmet need are determined by common antecedent factor such as education (Singh and Casterline 1985).

High socio-economic status is assumed to affect the unmet need for family planning directly and positively. A person with higher status implies high education and occupation in a high position. Higher socio-economic status opens up the horizon of a person's perception, helps to change traditional and dysfunctional attitudes, norms, and values to modern and functional ones. It also generally generates rational calculation and modern thought (Repetto 1979).

As a result, it is expected that most men of high status and some men of medium status will be using contraceptives and will have enough knowledge about contraceptive methods, have idea how to get family planning services, which in turn affects the unmet need for family planning. Surely, these men will have lower unmet need for family planning than men of low socio-economic status. Thus socio-economic status not only affects unmet need directly, but it also affects knowledge about contraceptive methods, availability of the family planning services, which means socio-economic status has both direct and indirect effects on the unmet need for family planning (Ahmad 1991). Socio-economic status can also affect the number of children a man has. Men involved in the job market will see additional children costs to time and money, and also generate additional responsibility of maintaining and rearing more children. These men are more likely to have some idea about the number of children they want, what time would be the best to have another baby, and also anticipate the future support they will get from their children, which is not the case for men of low socio-economic status (Simmons 1996).
Some researchers argued from the service point of view when discussing the unmet need for family planning. These researchers stated that the availability of the family planning methods, knowledge about contraceptive methods, concern about health and side effects, and variation in service quality were the principal determinants for unmet need (Bongaarts and Bruce 1995; Casterline et al. 1997; and Casterline and Sinding 2000). Sure, couples must have the contraceptives in order to practice them. It would not be surprising to see a direct relationship between the availability of a method and the prevalence of its use. In addition, knowledge about contraceptives also bears a direct relationship to the unmet need for family planning.

Though knowledge about contraceptives is an important aspect in identifying unmet need, this concept has serious limitations. For example, if a man were not interested in talking about fertility regulations, he would not give correct information or would be reluctant to answer questions that are asked by researchers. Another obstacle comes from health concerns, which may discourage people from using contraceptives. Some health concerns are life threatening for women, while others are non-life threatening, including common physiological effects such as nausea, headache, weight gain, increased menstrual bleedings, dysmenorrhea, and menstrual changes, and in the case of sterilization, irreversibility. However, the same magnitude of side effects is not found for men’s contraceptives, except for vasectomy (which in only some cases reversible). Man has additional fear of losing sexual gratification, while using condoms or having a vasectomy. Cultural beliefs may affect how men perceive fertility, health impacts of using contraceptives may actually lead to non-use of contraceptives. Many men could not or would not use contraceptives because of the objection from religious or
community leaders, and sometimes even from parents (Bernhart and Moslehuddin 1990; Pachauri 2001).

Taking availability of the family planning services as the point of reference, it is often assumed that service quality influences the unmet need for family planning. By improving the family planning services and making contraceptives easier to obtain and use will help meet the needs of many men (Johns Hopkins University Population Information Program 1996). In most cases, we assume that a lack of family planning services would generate unmet need for family planning. In reality, however, it could work either way. If a person does not get proper family planning services, we would not expect successful and desired reproductive goals. For developing countries, the relationship could be the other way around. Since most people are illiterate and are not concerned about the consequences of high population growth, if they don’t get services, it might be possible that they would not have the knowledge about contraceptive methods which will in turn lead to unmet need for family planning.

HYPOTHESES

Guided by the literature review, the present study attempts to test five specific hypotheses regarding the determinants of men’s unmet need for family planning in Bangladesh.

H_1: The higher the socio-economic status, the lower the men’s unmet need for family planning in Bangladesh.

Men with higher socio-economic status will be more responsive to change including limiting family size. As they are placed in upper strata, they could have more knowledge
about the consequences of having extra baby, get family planning services they need and have clear idea where to get contraceptive methods, all of which will in turn affect the unmet need for family planning.

**H2.** The higher the age, the higher the men’s unmet need for family planning in Bangladesh.

From the literature we found that as age increases, until 35-39, the unmet need for family planning increases but it decreases after 39. However, Bangladesh and Pakistan are different. The unmet need declines in both countries at a later age, after 45-49 years. The rationale here is that men would have reached their desired reproductive goal in terms of number of children as their age increases which will lead them stop thinking about more children and if they don’t get proper service from family planning program, these people might have higher unmet need for family planning.

**H3.** The more children a man has, the higher the men’s unmet need for family planning in Bangladesh.

As men reached their desired number of children, they are more interested in regulating fertility and hence increasing their demand for family planning. If they cannot meet their demand, they will report having higher unmet need for family planning.

**H4.** The lower the service availability, the higher the men’s unmet need for family planning in Bangladesh.

Couples are willing to go to distant places if better service is not available near home. If they don’t get proper information, not visited by family planning workers, they might be in need of family planning services. It could be said that lower service availability would generate higher unmet need for family planning.
H5: The higher the knowledge about contraceptive methods, the lower the men’s unmet need for family planning in Bangladesh.

Men who have less knowledge about contraceptive methods, will exhibit higher unmet need for family planning than men who have better knowledge about contraceptive methods.
CHAPTER III
METHODOLOGY

This study will focus on the determinants of men's unmet need for family planning in Bangladesh. It is designed to examine whether individual characteristics, socio-economic status, availability of the family planning services, and knowledge about contraceptive methods affect men's unmet need for family planning in Bangladesh. This chapter is divided into five sections, including data sources, sample, variables and measurement, techniques of analysis, and limitation of the study.

DATA SOURCE

To identify the determinants of men's unmet need for family planning, I used part of the data from the Demographic and Health Survey 1996-97 of Bangladesh (popularly known as BDHS), collected by Bangladesh's National Institute of Population Research and Training (NIPORT) of the Ministry of Health and Family Welfare. Mitra and Associates (a non-government research organization) implemented the survey. The Macro International Inc. of Calverton, Maryland provided technical assistance, and the U.S. Agency for the International Development (USAID/Bangladesh) gave financial assistance for the survey.

SAMPLE

The BDHS employed a two-stage sampling procedure. The samples were selected from the Integrated Multi-Purpose Master Sample (IMPS), originally formulated by
Bangladesh Bureau of Statistics. The administrative units are divided into three parts in Bangladesh- six administrative divisions, 64 districts, and 490 thanas (rural unit). Each division was divided into three groups - 1. Statistical metropolitan areas (SMAs), 2. Municipalities (other urban areas), and 3. Rural areas. For rural area, sampling unit was mauzas (administrative unit for rural area) and for urban areas, the primary sampling unit was mahallas (administrative unit for urban area). Primary sampling unit of IMPS were selected with a probability proportional to population size based on the 1991 census.

In the first stage, a systematic sample of 9,099 households was selected from household lists. In the second stage, every second household was selected for the men’s survey. Total 3284 currently married men age 15-60 were interviewed. These married men were the sample used in the present study. However, the BDHS did not give details about the two-stage sampling procedure, specifically no details were provided for how they selected the primary sampling units and how they drew households from the primary sampling units. The men’s survey, which contained structured questions, provides information on background characteristics, knowledge and use of family planning services, marriage, fertility preferences, and knowledge of AIDS.

VARIABLES AND MEASUREMENT

Dependent Variable

The dependent variable, Unmet Need for family planning, is derived from the following two items: (1) whether men want no more children, or to postpone next children for two or more years and (2) whether they are using any contraceptive method currently. If answer is “yes” for item (1) and “no” for item (2), a new variable will be
created as “unmet need for family planning”. This variable will be measured at the
nominal level. Men who have unmet need for family planning will be coded as “1” and
who do not have unmet need for family planning will be coded as “0”.

Independent Variables

Current age will be measured in the analysis at the interval level. Number of
children will be measured at the interval level. Two items, education, and occupation
were used to measure individual’s socio-economic status. Education will be defined as
years of schooling completed by men, and this is an interval level variable. Occupation
will be defined as the main profession by which a person earned his livelihood. This is
a nominal level variable.

Availability of the Family Planning Services was constructed based on three
items- (1) Whether family planning workers have ever discussed condoms with him, (2)
whether family planning workers have ever discussed male sterilization with him and (3)
whether family planning workers came to visit his house to discuss contraceptive
methods with him. These indicators are originally measured at nominal level, since they
include “yes” and “no” categories. “Yes” is coded as “1” and no response is coded as “0”.

Knowledge about Contraceptive Methods is measured by two indicators-whether
men knew a place where he can get methods for family planning and whether men knew
how to use a contraceptive method (condom). These indicators are originally measured at
the nominal level, since they include “yes” and “no” categories. Yes is coded as “1” and
no is coded as “0”.
TECHNIQUE OF ANALYSIS

Data analysis will be performed at three levels - (1) at univariate level, (2) at bivariate level, and (3) at multivariate level. Univariate analysis will be conducted to describe demographic and socio-economic background of the sample (e.g., age, level of education, occupation, and number of children), availability of the family planning services and knowledge about contraceptive methods. Frequencies, percentages, means and medians will be presented at this level of analysis.

At the bivariate level, cross tabulations will be used to assess the relationship between dependent and independent variables. The chi-square goodness of fit test, and t-test will be used to test the association between unmet need for family planning and the independent variables, such as age, number of children, socio-economic status, availability of the family planning services, and knowledge about contraceptive methods.

The third set of analysis will be conducted at the multivariate level. In particular, I will use Logistic Regression to assess the potential correlates of men’s unmet need for family planning in Bangladesh. The dependent variable of this study is dichotomous in nature, whereas many of the independent variables are measured at other levels. We have traditionally dealt with the analysis of variables measured at different levels by categorization of continuous variables, thereby losing a large amount of information. Logistic regression circumvents these problems. This technique allows us to analyze the effects of a set of independent variables on a dichotomous dependent variable with minimal statistical bias and loss of information. Since the probability of a dichotomous event coded “0” and “1” must range within those values (0 indicating zero probability and 1 indicating certainty), making predictions from Ordinary Least Square (OLS)
regression with a dichotomous dependent variable can often lead to predictions outside the possible range, (i.e., less than “0” or more than “1”) (Walsh 1990). As a non-linear predictor model, the logistic regression technique allows me to assess the relative importance of the independent variables of age, number of children, socio-economic status, availability of the family planning services and knowledge about contraceptive methods in determining the men’s unmet need for family planning in Bangladesh.

LIMITATION OF THE STUDY

No research is perfect in any sense. The major limitation of this study relates to the data. As the data I use are from secondary sources, it would not be possible to cover issues like knowledge about male sterilization, withdrawal method etc. Second, this study will not perform separate analysis for spacers and limiters to identify the unmet need among men due to time constraints. Third, the findings from this study may not be generalized to other countries. Fourth limitation is related to the definition of unmet need for family planning. If a man is not currently using any contraceptive methods and wants to control fertility, according to the definition of unmet need, they have unmet need. However, there remains a hidden issue. There is a possibility that a man does not have unmet need, because his wife is using contraceptives. But by definition, these men are also included in the analysis of unmet need for family planning, which might overestimate men’s unmet need for family planning. However, this may not be a problem if men perceive that “they” are using contraception if “she” is.
In this chapter, I present the effects of age, socio-economic status, number of children, availability of the family planning services, and knowledge about contraceptive methods on the unmet need for family planning. The data consist of currently married men (n=3284), age 15-60+, from a nationally representative survey conducted between 1996 and 1997. The original data were obtained from the Bangladesh Demographic and Health Survey (BDHS) 1996-97 and fieldwork for BDHS took place from early November 1996 to mid-March 1997. In this chapter, descriptive statistics are discussed first, followed by the results of bivariate analysis and logistics regression.

UNIVARIATE RESULTS

Table 1 reports the data on currently married men age 15-60+. The mean age is 39.2 years. Table 1 also describes the number of children of currently married men. Although considerable incentive has been given to couples who have few children and family planning programs have provided to outreach clients, the number of children still remains high in Bangladesh. Most of the respondents have more than 3 children (55.9 percent). Only nine percent do not have any children. Of course this does not necessarily mean that these men will not have children at some time. The data of this study reveals that the mean number of children among men is 3.00. Overall, the mean ideal number of children among men in Bangladesh is 2.5 children (Bangladesh Bureau of Statistics 1991).
Table 1. The Percentage Distribution of Currently Married Men by Age Group and Number of Children, 1996-97

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Frequency</th>
<th>Valid Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>15-19</td>
<td>19</td>
<td>.6</td>
</tr>
<tr>
<td>20-24</td>
<td>166</td>
<td>5.1</td>
</tr>
<tr>
<td>25-29</td>
<td>468</td>
<td>14.3</td>
</tr>
<tr>
<td>30-34</td>
<td>649</td>
<td>19.8</td>
</tr>
<tr>
<td>35-39</td>
<td>575</td>
<td>17.5</td>
</tr>
<tr>
<td>40-44</td>
<td>410</td>
<td>12.5</td>
</tr>
<tr>
<td>45-49</td>
<td>328</td>
<td>10.0</td>
</tr>
<tr>
<td>50-54</td>
<td>272</td>
<td>8.3</td>
</tr>
<tr>
<td>55-59</td>
<td>230</td>
<td>7.0</td>
</tr>
<tr>
<td>60+</td>
<td>167</td>
<td>5.1</td>
</tr>
<tr>
<td>Total</td>
<td>3284</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Mean Age = 39.2 years

<table>
<thead>
<tr>
<th>Number of Children</th>
<th>Frequency</th>
<th>Valid Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>303</td>
<td>9.2</td>
</tr>
<tr>
<td>1</td>
<td>509</td>
<td>15.5</td>
</tr>
<tr>
<td>2</td>
<td>637</td>
<td>19.4</td>
</tr>
<tr>
<td>3-4</td>
<td>1004</td>
<td>30.6</td>
</tr>
<tr>
<td>5+</td>
<td>831</td>
<td>25.3</td>
</tr>
<tr>
<td>Total</td>
<td>3284</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Mean Number of Children = 3
Table 2 represents two indicators of socio-economic status of currently married men in Bangladesh. Education is a key determinant of the life style and status an individual enjoys. It affects almost all aspects of life, including health behavior. Although education has become more widespread in Bangladesh, levels of educational attainment still remain low. Almost 41 percent of men have not received any formal education. Only 30.8 percent of the sample received primary education (i.e., 5 years of education) and very few (8.1 percent) of respondents have more than 12 years of education. The median number of school years is only 2 years among the respondents of this study. The median number of years of schooling in Bangladesh is 1.7 years for men and less than 1 full year for women (Bangladesh Bureau of Statistics 1991).

Table 2 also indicates the types of occupations in which working men are engaged. As expected, agricultural jobs are common in Bangladesh. Almost 36 percent of men are self-employed in agriculture and 13 percent employ other people to do jobs on their land. Another 24.5 percent are manual laborers, with 7.8 percent engaged in skilled laborer and 16.7 percent in unskilled laborer. Only 6 percent of working men were employed in professional, technical or managerial jobs. Nineteen percent of the total sample work in sales. This is typical of Bangladesh where doing small informal businesses in particular market places called “Hat” or “Bazar” is popular. Interestingly only 1.4 percent of men report being not involved with any kind of employment.
Table 2. The Percentage Distribution of Currently Married Men by Socio-economic Status, 1996-97

<table>
<thead>
<tr>
<th>Socio-economic Status</th>
<th>Frequency</th>
<th>Valid Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Level of Education</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No Education</td>
<td>1344</td>
<td>40.9</td>
</tr>
<tr>
<td>Primary</td>
<td>1011</td>
<td>30.8</td>
</tr>
<tr>
<td>Secondary</td>
<td>664</td>
<td>20.2</td>
</tr>
<tr>
<td>Higher</td>
<td>265</td>
<td>8.1</td>
</tr>
<tr>
<td>Total</td>
<td>3285</td>
<td>100.0</td>
</tr>
<tr>
<td><strong>Occupation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agriculture-self employed</td>
<td>1172</td>
<td>35.7</td>
</tr>
<tr>
<td>Agriculture-employee</td>
<td>425</td>
<td>12.9</td>
</tr>
<tr>
<td>Sales</td>
<td>620</td>
<td>18.9</td>
</tr>
<tr>
<td>Skilled Manual Labor</td>
<td>256</td>
<td>7.8</td>
</tr>
<tr>
<td>Unskilled Manual Labor</td>
<td>549</td>
<td>16.7</td>
</tr>
<tr>
<td>Professional, Technical and Managerial</td>
<td>197</td>
<td>6.0</td>
</tr>
<tr>
<td>Not Working</td>
<td>46</td>
<td>1.4</td>
</tr>
<tr>
<td>Total</td>
<td>3265</td>
<td>100.0</td>
</tr>
</tbody>
</table>
The percentage of currently married men by visitation of family planning workers is presented in Table 3. Almost 60 percent of men had either been visited or had contact with a family planning worker. The fact that 60 percent of married men are being visited by family planning workers is cause for concern, since virtually the entire country is covered by family planning workers. This is a clear indication that family planning worker coverage may have deteriorated. According to policy makers, 100 percent of men should get visited by family planning workers (Mabud, Ahsan, Rahman, and Rahman 1996). In 1996-97, 35 percent of currently married women said a family planning worker had visited them in the previous 6 months, down from 38 percent in 1993-94. No such data exist for men in Bangladesh.

Availability of the family planning services is measured by whether family planning workers discussed with men their desired contraceptive methods. About 75.6 percent of men said that condoms had been discussed as a method of regulating fertility (See Table 4). On the contrary, 24.4 percent of men reported that they have not discussed about condom with family planning workers. As a method of regulating fertility, male sterilization is more often discussed than condoms in Bangladesh. Almost 92.4 percent of men said that they spoke to family planning worker about male sterilization.

Sources of family planning methods play an important role in the promotion and maintenance of contraceptive use levels in the population. Whether men knew the source of method used as an indicator of knowledge about contraceptive methods. Knowledge about sources of contraceptive method is high; 88 percent of men knew where they could get contraceptives (See Table 5). Only 12 percent did not know about the methods discussed. Approximately 66.4 percent of men reported that they knew condom should
use whenever they have sex (See Table 5). About 34 percent of men said that they did not know how to use condom.

The dependent variable of the study- the unmet need for family planning- is presented in Table 6. Almost 40 percent of men reported that they have unmet need for family planning. This indicates that men are ‘potential clients’ for successful family planning programs and men need proper attention from policy makers. Data from 1993-94 Bangladesh Demographic and Health Surveys show that 19 percent of currently women were in need of family planning services.
Table 3. The Percentage Distribution of Currently Married Men by Visits by Family Planning Worker in Last 6 Months, 1996-97

<table>
<thead>
<tr>
<th>Visits by Family Planning Worker in Last 6 Months</th>
<th>Frequency</th>
<th>Valid Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Visits</td>
<td>1370</td>
<td>41.8</td>
</tr>
<tr>
<td>Visits</td>
<td>1907</td>
<td>58.2</td>
</tr>
<tr>
<td>Total</td>
<td>3284</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Table 4. The Percentage Distribution of Currently Married Men by Method Discussed (condom and male sterilization) with FPW, 1996-97

<table>
<thead>
<tr>
<th>Method Discussed with FPW</th>
<th>Frequency</th>
<th>Valid Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condom</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not Discussed</td>
<td>457</td>
<td>24.4</td>
</tr>
<tr>
<td>Discussed</td>
<td>1414</td>
<td>75.6</td>
</tr>
<tr>
<td>Total</td>
<td>1871</td>
<td>100.0</td>
</tr>
<tr>
<td>Missing Cases</td>
<td>36</td>
<td></td>
</tr>
<tr>
<td>Male Sterilization</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not Discussed</td>
<td>143</td>
<td>7.6</td>
</tr>
<tr>
<td>Discussed</td>
<td>1728</td>
<td>92.4</td>
</tr>
<tr>
<td>Total</td>
<td>1871</td>
<td>100.0</td>
</tr>
<tr>
<td>Missing Cases</td>
<td>36</td>
<td></td>
</tr>
</tbody>
</table>

Table 5. The Percentage Distribution of Currently Married Men by Knowledge about Sources of Methods and Knowledge about How to Use Condom, 1996-97

<table>
<thead>
<tr>
<th>Knows Source of Method</th>
<th>Frequency</th>
<th>Valid Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>170</td>
<td>12.0</td>
</tr>
<tr>
<td>Yes</td>
<td>1244</td>
<td>88.0</td>
</tr>
<tr>
<td>Total</td>
<td>1414</td>
<td>100.0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Have Knowledge about How to Use Condom</th>
<th>Frequency</th>
<th>Valid Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>48</td>
<td>33.6</td>
</tr>
<tr>
<td>Yes</td>
<td>95</td>
<td>66.4</td>
</tr>
<tr>
<td>Total</td>
<td>143</td>
<td>100.0</td>
</tr>
</tbody>
</table>
Table 6. The Percentage Distribution of Currently Married Men by Unmet Need for Family Planning, 1996-97

<table>
<thead>
<tr>
<th>Unmet Need for Family Planning</th>
<th>Frequency</th>
<th>Valid Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>1944</td>
<td>59.2</td>
</tr>
<tr>
<td>Yes</td>
<td>1340</td>
<td>40.8</td>
</tr>
<tr>
<td>Total</td>
<td>3284</td>
<td>100.0</td>
</tr>
</tbody>
</table>
BIVARIATE RESULTS

Bivariate crosstabulations provide an assessment of the relationship between the dependent and independent variables prior to estimating the full model. Chi-square and t-tests are used to detect the significance of relationships, using a critical value of $p \leq 0.05$.

Table 7 presents the relationship between unmet need for family planning and socio-economic status, measured here by years of schooling completed by men. Hypothesis 1 predicts that the higher the socio-economic status, the lower the men's unmet need for family planning. The t-test indicates that the unmet need for family planning and education were significantly related. Men with a high level of education have low levels of unmet need for family planning. As expected earlier, men with secondary or higher schooling have markedly lower levels of unmet need for family planning.

Similarly the results in Table 8 show that men with low socio-economic status measured by occupation have higher unmet need for family planning than those in higher socio-economic occupations. The results indicate that men who were not working, involved in agriculture and manual labor have higher rates of unmet need for family planning than those who were involved in professional, technical and managerial occupations. Men who were employed by other people have the highest rate of (44.5 percent) unmet need for family planning, followed by those who were unskilled manual laborer (43.4 percent), self-employed agriculture workers (42.2 percent), currently not working (41.3 percent), skilled manual laborers (39.1 percent) and sales (38.2 percent) (Chi-square = 20.294, $p < .05$)
The second hypothesis of the study is “the higher the age, the higher the men’s unmet need for family planning.” The result of the t-test provided in Table 7 indicates that unmet need for family planning and age were significantly related. The results show that unmet need for family planning increases with age.

Hypothesis 3 is “the more children a man has, the higher the men’s unmet need for family planning.” Table 7 presents the relationship between unmet need for family planning and number of children. The t-test shows that unmet need for family planning and number of children was significantly related. Unmet need for family planning increases with the number of children.
Table 7. Mean Number of Unmet Need for Family Planning by Age, Number of Children and Years of Schooling Completed by Men, 1996-97

<table>
<thead>
<tr>
<th></th>
<th>Current Age of Men</th>
<th>Number of Children</th>
<th>Year of Schooling</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>Std</td>
<td>n</td>
</tr>
<tr>
<td>Unmet Need for Family</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Planning</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Met Needs</td>
<td>40.10</td>
<td>10.480</td>
<td>1944</td>
</tr>
<tr>
<td>Unmet Need</td>
<td>37.88</td>
<td>12.026</td>
<td>1340</td>
</tr>
<tr>
<td>*p&lt;0.05</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 8. The Percentage Distribution of Men's Unmet Need for Family Planning by Occupation, 1996-97

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Unmet Need for Family Planning</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Met Needs n = 1933 Unmet Need n = 1332</td>
</tr>
<tr>
<td>Agriculture-self employed</td>
<td>57.8</td>
</tr>
<tr>
<td>Agriculture-employee</td>
<td>55.5</td>
</tr>
<tr>
<td>Sales</td>
<td>61.8</td>
</tr>
<tr>
<td>Skilled Manual Labor</td>
<td>60.9</td>
</tr>
<tr>
<td>Unskilled Manual Labor</td>
<td>56.6</td>
</tr>
<tr>
<td>Professional, Technical and Managerial</td>
<td>72.1</td>
</tr>
<tr>
<td>Not Working</td>
<td>58.7</td>
</tr>
</tbody>
</table>

* p<0.05
Hypothesis 4 predicts that the lower the service availability, the higher the men’s unmet need for family planning. Availability of the family planning services is measured by three indicators- (1) whether family planning workers have visited the respondent and (2) whether family planning workers came to the respondents house to discuss condom use with him and (3) whether family planning workers have ever discussed male sterilization with him. Table 9 show that those who have been visited by family planning workers have low rate of reported unmet need for family planning (36.3 percent) compared to those who were not (46.9 percent)(Chi-square = 37.058, p <. 05).

Table 9 presents another indicator of availability of the family planning services in relation to unmet need for family planning. The assumption here is that if a family planning worker discussed different methods of contraception it usually encourages the use of contraception, eventually leading to lower unmet need for family planning. Interestingly enough, the results were quite the opposite. If methods were discussed, the rate of unmet need for family planning became even higher. For example, if condoms were not discussed with family planning worker, about 71 percent men said that they didn’t have unmet need for family planning as opposed to 29 percent of men have unmet need for family planning. The same pattern is also found in the case of male sterilization. It could be inferred that discussion of methods are not only factors in relation to service that affect unmet need for family planning. It could be the fact that they did not receive supplies from family planning workers, which is reality for a poor country like Bangladesh. Clients feel encouraged if they got contraceptive methods from family planning workers, instead of paying for contraceptives.
Hypothesis 5 predicts that the higher the knowledge about contraceptive methods, the lower the men’s unmet need for family planning. Table 10 shows the result of a chi-square test (chi-square = 4.167, p < .05). Men who have no idea where to get contraceptive methods have a higher unmet need for family planning (91 percent). However, if they do know a source, the unmet need for family planning is still high enough (94.5 percent). The result does not support hypothesis 5.
Table 9. The Percentage Distribution of Men’s Unmet Need for Family Planning by Visits of Family Planning Worker and Methods Discussed with Family Planning Worker, 1996-97

<table>
<thead>
<tr>
<th>Visits by Family Planning Worker</th>
<th>Met Needs n = 1941</th>
<th>Unmet Need n = 1336</th>
<th>Chi-square</th>
<th>df</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Visits</td>
<td>53.1</td>
<td>46.9</td>
<td>37.085</td>
<td>1</td>
</tr>
<tr>
<td>Visits</td>
<td>63.7</td>
<td>36.3</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Method Discussed with FPW (condom) n = 1924 n = 1320

<table>
<thead>
<tr>
<th>Method Discussed with FPW (condom)</th>
<th>Met Needs n = 1924</th>
<th>Unmet Need n = 1320</th>
<th>Chi-square</th>
<th>df</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Discussed</td>
<td>70.7</td>
<td>29.3</td>
<td>28.489</td>
<td>1</td>
</tr>
<tr>
<td>Discussed</td>
<td>57.4</td>
<td>42.6</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* p≤ .05

Table 10. The Percentage Distribution of Men’s Unmet Need for Family Planning by Knowledge about Source of Contraceptive Methods, 1996-97

<table>
<thead>
<tr>
<th>Knows Source of Contraceptive Methods</th>
<th>Met Needs n = 84</th>
<th>Unmet Need n = 1484</th>
<th>Chi-square</th>
<th>df</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>9.4</td>
<td>90.6</td>
<td>4.617</td>
<td>1</td>
</tr>
<tr>
<td>Yes</td>
<td>5.5</td>
<td>94.5</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* p≤ .05
The first model is designed to test the first four of the five stated hypotheses. Table 11 shows the first model which shows the effects of age, number of children, socio-economic status (measured by education, occupation), and availability of the family planning services on having unmet need for family planning among men. Respondents who are self-employed in agriculture stand as reference category for all other occupational categories. No visits by family planning workers and no discussion about methods (condom and male sterilization) with family planning workers stand as reference category for three indicators of availability of the family planning services. The model explains only 6 percent of the variation in having unmet need for family planning. Age and two of the three indicators of availability of the family planning services are found to be statistically significant—visits of family planning workers and methods (condom) discussed with family planning worker. This result supports hypothesis 3 and partially supports hypothesis 4.

The third indicator of availability of the family planning services—whether male sterilization is discussed with family planning worker is not statistically significant. Part of the reason is that levels of male sterilization are now very low in Bangladesh. Men are not willing to opt for a method, which will stop their ability to have children. Clearly, a major priority for the Bangladesh family planning program would be to strengthen cultural support for male sterilization over the coming years.

Visit by family planning workers appears to be a stronger predictor of having unmet need for family planning. The likelihood of having the unmet need for family
planning could be attributed to the visits by family planning workers. Despite impressive coverage by family planning workers, household visitation remains low.

The second model of logistic regression is designed to test hypotheses. Interestingly, only one of the variables is statistically significant - age - and the model explains 27 percent of the variation of having unmet need for family planning. The result only supports hypothesis 2. However, the results show that having unmet need for family planning is not related to education, occupation, availability of the family planning services and knowledge about contraceptive methods. The addition of knowledge about contraceptive methods actually increases explanatory power of the model, at the same time number of children and two indicators of availability of the family planning services lost the statistical significance. The reason might be the vast number of missing cases, which came as a result of including the variable-knowledge about contraceptive methods- in the logistic regression model.

Knowledge of at least one family planning method is universal among married Bangladeshi women (Mitra, Ali, Islam, Cross, and Saha 1994), which is not the case for men. More importantly, virtually all respondents who know at least one method know a modern method. This knowledge has been confirmed by asking the question about the knowledge about source of contraception, that produce a large number of missing cases, which gives the idea that there is still scope to increase the amount of information that is known about specific method of contraception. In addition, learning of these methods or sources of methods through informal channels is not easy in a society like Bangladesh where matters relating to sex are not freely discussed.
In the second model, a high Exponential (B) is shown for the third indicators of availability of the family planning service—whether male sterilization is discussed with family planning workers. This could be the result of missing cases in the model.

In summary, if we consider the first model, the majority of the hypotheses are supported. However, if we consider the second model, only one hypothesis is supported. The next chapter will discuss the research findings in greater detail and the policy implications that can be drawn from the findings. It will also discuss the future directions for research as well as some limitations in the data that should be addressed in future studies.
Table 11. Logistic Regression Model Predicting Men’s Unmet Need for Family Planning, 1996-97

<table>
<thead>
<tr>
<th>Model</th>
<th>( B )</th>
<th>Wald Chi-square</th>
<th>( \exp(B) )</th>
<th>2-Log L (p)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>-.001</td>
<td>.031</td>
<td>.999</td>
<td></td>
</tr>
<tr>
<td>Number of Children</td>
<td>-.122</td>
<td>15.309</td>
<td>.885*</td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td>-.050</td>
<td>2.426</td>
<td>.952</td>
<td></td>
</tr>
<tr>
<td>Occupation 1</td>
<td>.304</td>
<td>.612</td>
<td>1.356</td>
<td></td>
</tr>
<tr>
<td>Occupation 2</td>
<td>.405</td>
<td>.928</td>
<td>1.499</td>
<td></td>
</tr>
<tr>
<td>Occupation 3</td>
<td>-.012</td>
<td>.001</td>
<td>.998</td>
<td></td>
</tr>
<tr>
<td>Occupation 4</td>
<td>-.165</td>
<td>.156</td>
<td>.848</td>
<td></td>
</tr>
<tr>
<td>Occupation 5</td>
<td>.143</td>
<td>.127</td>
<td>1.154</td>
<td></td>
</tr>
<tr>
<td>Occupation 6</td>
<td>-.179</td>
<td>.185</td>
<td>.836</td>
<td></td>
</tr>
<tr>
<td>Servav 1</td>
<td>.314</td>
<td>15.301</td>
<td>1.536*</td>
<td></td>
</tr>
<tr>
<td>Servav 2</td>
<td>-.301</td>
<td>5.485</td>
<td>.685*</td>
<td></td>
</tr>
<tr>
<td>Servav 3</td>
<td>-.311</td>
<td>2.012</td>
<td>.600</td>
<td></td>
</tr>
<tr>
<td>Constant</td>
<td>.362</td>
<td>4.926</td>
<td>.648</td>
<td></td>
</tr>
<tr>
<td>Nagelkerke r-square</td>
<td>.06</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>n = 1895</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(2)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>-.904</td>
<td>30.151</td>
<td>.910*</td>
<td>256.909*</td>
</tr>
<tr>
<td>Number of Children</td>
<td>-.023</td>
<td>0.83</td>
<td>.977</td>
<td></td>
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<tr>
<td>Education</td>
<td>-.123</td>
<td>1.197</td>
<td>.884</td>
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<tr>
<td>Occupation 1</td>
<td>-.028</td>
<td>.001</td>
<td>.972</td>
<td></td>
</tr>
<tr>
<td>Occupation 2</td>
<td>-.319</td>
<td>.117</td>
<td>.727</td>
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</tr>
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<td>Occupation 3</td>
<td>.539</td>
<td>.311</td>
<td>1.714</td>
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</tr>
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<td>Occupation 4</td>
<td>.267</td>
<td>.060</td>
<td>1.306</td>
<td></td>
</tr>
<tr>
<td>Occupation 5</td>
<td>-.599</td>
<td>.439</td>
<td>.549</td>
<td></td>
</tr>
<tr>
<td>Occupation 6</td>
<td>1.066</td>
<td>.654</td>
<td>2.903</td>
<td></td>
</tr>
<tr>
<td>Servav 1</td>
<td>.518</td>
<td>2.161</td>
<td>1.679</td>
<td></td>
</tr>
<tr>
<td>Servav 2</td>
<td>1.287</td>
<td>1.450</td>
<td>3.622</td>
<td></td>
</tr>
<tr>
<td>Servav 3</td>
<td>4.773</td>
<td>.136</td>
<td>118.308</td>
<td></td>
</tr>
<tr>
<td>Knowld 1</td>
<td>-.258</td>
<td>.190</td>
<td>.773</td>
<td></td>
</tr>
<tr>
<td>Constant</td>
<td>7.294</td>
<td>29.343</td>
<td>1470.742</td>
<td></td>
</tr>
<tr>
<td>Nagelkerke r-square</td>
<td>.27</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>n = 734</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Significant at p≤.05
CHAPTER V
DISCUSSIONS AND CONCLUSIONS

This chapter reviews the findings of this study of the impacts of individual characteristics, availability of the family planning services and knowledge about contraceptive methods on men's unmet need for family planning in Bangladesh. In addition, the limitations of data and the extent to which the findings support the hypotheses are reported. Finally, policy implications and recommendations for future study are considered.

DATA CONSTRAINTS

Essentially, this study attempted to focus on the unmet need for family planning in Bangladesh. As the data used in this study came from a secondary source, and focuses on men only, this is a difficult task. Working with secondary sources can create a variety of problems including the lack of required variables, missing data and small cell sizes in the tables.

The definition of unmet need for family planning presented one problem in the analysis. This study defines unmet need for family planning when men reported willingness for regulating fertility but were not currently using contraceptives. However, the data set did not include whether their wives were using any contraceptives. If they do, then these men might not to be included in the analysis for having unmet need for family planning.
Most of the problems related to the data stem from the missing cases. For instance, income is a good indicator of socio-economic status but was not available in the data set. This study also faced problems with missing data for the variable concerning knowledge about contraceptive methods. This study used two indicators of knowledge – (1) whether men know sources where to get contraceptive methods and (2) whether they have knowledge about how to use condoms. One problem is that if men said that he knows about any contraceptive methods, only then further question is asked whether they knew sources of contraceptive methods in survey questionnaire. This produced many missing cases for indicator of knowledge. Concerning the second indicator, only a few men have knowledge about how to use condoms and as a result there were many missing cases, that ultimately caused me to drop this variable from the bivariate and multivariate level analyses.

DISCUSSION OF THE RESULTS

This study is designed to explore the relationship between men’s unmet need for family planning with individual characteristics, availability of the family planning services, and knowledge about contraceptive methods among a national sample of currently married men age 15-60+. This study reveals some important findings concerning the differentials present in the level of unmet need for family planning among men. These findings will provide much needed guidelines for redesigning programs.

Bangladesh has achieved considerable success in its family planning programs resulting in markedly decline in fertility. The findings of the study that men have substantial levels of unmet need for family planning increased optimism concerning the
role of family planning programs in the transition toward lower fertility. Because men play a dominant role in couples fertility decisions, satisfying men's unmet need for family planning may hasten fertility transitions in Bangladesh. The demographic significance of the concept of unmet need lies not only in the implied change of finding a way to satisfy potential family planning demand but also in the expected subsequent effects on fertility levels of doing so. Obviously, such challenges cannot be met without involving men. Certainly, the satisfaction of unmet need and subsequent fertility decline are related to the ability of husbands and wives to reach their common reproductive goals. Communication programs that foster spousal interaction may facilitate the satisfaction of both partners' unmet need for family planning (Ngom 1997).

The main predictors of unmet need for family planning were found to be age (in the second model, See Table 11), number of children and availability of the family planning services (in the first model, See Table 11). However, there might have been some causal connections why unmet need family planning varies with those predictors.

Regarding the association between socio-economic status (measured by education and occupation) (See Table 7 and 8) and men's unmet need for family planning, the results are found to be significant. More educated men have greater motivation to use contraception to reach desired levels of family size goals. Men who were educated were more likely to know of or use family planning methods than were those who were less educated. However, education is a privilege, not an opportunity in Bangladesh. In an over-populated country so acutely short of investment resources as Bangladesh, population is a vital resource. In order for the masses to be receptive to forces of modernization as well as for them to make maximum use of the services provided by the
government for changing conditions of life, education is an essential. The participation rates in the educational system are directly proportional to the economic status and therefore, educational system is socially inequitable.

The per capita cost of education is 60 percent higher in the secondary than in the primary levels and is twice as high at the college level. Participation in higher levels of education is heavily weighted in favor of the higher income groups (Islam 1978). This might help explain how education stands as crucial factor for causing high unmet need for family planning among some sections of society at the bivariate level. However, at the multivariate level, education has no impact on the likelihood of having unmet need for family planning.

Occupation, the other indicator of socio-economic status, is significantly related to unmet need for family planning (See Table 8). The results indicate that men who were not working, involved with agriculture, and manual labor have higher rates of unmet need for family planning than those who were involved in professional, technical and managerial type of occupation. However, occupation is not significant at the multivariate level.

The traditional attitude toward occupation is getting away from manual or physical work. Education is used as a means to gain access to white collar occupations. The bias toward white-collar occupation is encouraged by the absence of employment opportunities for those completing primary and secondary education. The prejudice against manual work and vocational training which is associated with work outside an office continues. On the other hand, unemployment among educated men is due partly to their not being able to get acceptable jobs in the market. As a whole, getting good
position in occupational ladder involves education. Higher education involves extra expenses from family, is directly related to the socio-economic status of the family. This explains that a large proportion of men is being involved with non-professional jobs in Bangladesh (Islam 1978). This reveals the fact that being involved with certain occupations is leading to high rate of unmet need of family planning.

As hypothesis 2 predicts, the higher the age, the higher the men’s unmet need for family planning. At the bivariate level, the result shows that age and unmet need for family planning are significantly related (See Table 7). Along with traditional culture, older men of Bangladesh rely largely on traditional methods for limiting birth. This group might be excluded from the current users of contraceptive methods, since they have been depending on methods, which do not belong to categories specified by the family planning workers. They were not using condoms or experiencing male sterilization, so what other methods could be used to define them as current users (Sabir and Ali 1993)? This subsequently results in unmet need for family planning among older men. Reliance on traditional methods may be due, in part, to unavailability of modern contraceptives. If this is true, then the results clearly suggest that there is a significant proportion of the target population having an unmet need for family planning. The program should try to meet this need by improving its existing service delivery systems.

Unmet need for family planning does differ significantly by the number of children in Bangladesh (See Table 7) at the bivariate level. Deteriorating economic conditions, the shrinking man-to-land ratio and declining mortality have intensified the existing demand for fertility regulation. Moreover, increasing exposure of the population to the mass media, and the expanded use of widespread communication networks, may
have brought people into contact with new ideas and stimuli (Amin and Choudhri 1987). These factors have created a favorable attitude toward having fewer children. As the number of children increases, couples felt demand for family planning services. Although demand for family planning did not change greatly over the years in Bangladesh, the result suggests that there has recently been an increase in the unmet need for family planning among high parity men. These findings suggest that the continued diffusion of notions of birth-limiting and birth-spacing throughout the population could be further encouraged by improving service.

At the multivariate level, the first model revealed that the number of children has a significant effect on the unmet need for family planning. However, this variable lost significance in the second model. As soon as knowledge about contraceptive methods was entered into the model (in the second model), most of the variables lost their significant relationship with the unmet need for family planning. As we have indicated that the present study dropped one of the indicators of knowledge about contraceptive methods because of large missing cases. When the second indicator (knowledge about source of method) was included in the model, we lost a large number of cases that might cause other variables to lose their significant effect on the unmet need for family planning.

In the first model, two indicators of the availability of family planning services—visit by family planning workers and methods discussed with (condom) family planning workers—are found to be significant. Visits by family planning workers appear to be a stronger predictor than methods discussed with (condom) family planning workers. However, whether male sterilization is discussed with family planning workers is not
statistically significant. Moreover, all three indicators lost their significance in the second model.

Couples cannot make use of modern methods of contraception if the appropriate services and supplies are not accessible. A visit from family planning worker can be a decisive factor in whether or not a couple adopts a contraceptive method. Family planning workers are supposed to visit 20 households a day, or to complete their visitation cycle in two months’ time. It is necessary to determine the optimum number of households a family planning worker can visit daily as well as the length of visitation cycle based on current workloads. However, a study (Mabud et al. 1996) reported that family planning workers spent about 11.8 days for home visits per month, contacting 19 clients per day. They also tend to visit oral contraceptive users more frequently, while giving lower priority to non-users and traditional method users. This implies increased emphasis should be given to family planning workers’ coverage and frequency of visits.

Until 1988, family planning workers (government, non-government service as well as ad hoc agents) received referral fees to cover conveyance costs for accompanying sterilization clients to clinics. However, there were some reports of abuse of the system especially by the agents that caused to stop referral fees from the government side. Since the abolition of fees, government and non-government workers have been reluctant, if not unable in some cases, to spend money out of their own pockets to take clients to clinics. The absence of travel funds is believed to have reduced the utilization of male sterilization service.

Men must be aware of contraceptive methods and must have sufficient information about different sources of methods. Eventually, they must know how to use
the method selected; this information can be acquired when obtaining the method, but in reality, uncertainty about sources of methods may serve as further informational obstacle to adopting a method. This may generate the unmet need for family planning among prospective users (Casterline et al. 1997). The results of the study (See Table 10) reveal that if men have no idea where to get contraceptive methods, they have higher unmet need for family planning. However, if they do know the source, the unmet need for family planning is still high. It is possible that if they do know the source of getting contraceptives, it does not necessarily mean that they are going to use contraceptive methods.

POLICY IMPLICATION

Unmet need for family planning is analyzed in order to identify the future strategies in formulating policies to increase the performance of family planning programs by minimizing unmet needs of the potential clients who are not current users of any method of contraception.

Traditional approaches tend to push more couples into unmet need status because they fail to consider the role of husbands in reproductive decision-making. The traditional formulation of the measure of unmet need ignores the role of husbands in reproductive decisions by assuming that husbands and wives have similar reproductive preferences and goals. Here I argue that husbands’ fertility intentions and contraceptive behavior are important ingredients for any measure of unmet need for family planning intended for couples. These arguments have implications for family planning programs.
Unmet need decreases sharply for respondents who have secondary and higher level of education in comparison to those who do not have any formal schooling. The findings of this research suggest that formal education for men should be encouraged. Increased literacy and the spread of education up to at least the primary level may be a formidable task. Much depends on the willingness and the commitment of the government towards this purpose. At present only 1.3 percent of the Gross Domestic Product (GDP) is spent on education. This is among the lowest percentages in the world. During the Fifth Five Year Plan (1995-2000), only 3.7 percent of the total development outlay was allocated for education (Ministry of Information 1995). The lack of commitment on the part of the government is also made apparent from the poor implementation of the literacy and mass education program, especially when it is compared to education at the university level. In addition to problems of finance, teachers, teaching materials, and curriculum, there is a basic problem at the organizational level. There is no integrated approach to the problem at the national level.

In this circumstance, adult literacy and vocational education programs are only a short-term solution. Given the resource constraints of the country and cultural barriers, the spread of education at the secondary level will take time. Finally, the emphasis should be shifted from university education to primary and secondary education with a strong vocational emphasis. As a consequence, occupational structure would have been changed which might positively affect the rate of unmet need for family planning. It is also necessary to incorporate men into different occupations and facilities, as a result it may be expected that it would bring changes in their status, which in turn lowers their desire for additional children and unmet need for family planning.
As our findings show that unmet need is higher among respondents age 25 through 34 as compared to respondents of age 15-24 years. This finding has far-reaching policy implications. This shows that there is a latent demand for contraception among relatively older people who were typically not reached by the family planning program. This finding suggests that this group needs more attention from policy makers of family planning programs.

The result also indicates that though family planning worker discussed male sterilization with men male sterilization, this variable comes out insignificant in the analysis. Clearly, a major priority for the Bangladesh family planning program will be to strengthen male sterilization over the coming years.

The overall findings of the study indicate that although “substantial” unmet need for family planning exists in the country, several factors may inhibit many of the non-users from practicing contraception in the future. Special attention should be given to improving the frequency and quality of family planning worker visits and strengthening the supervisory system. The program must also give due consideration to clients’ need. However, to improve contraceptive use among men requires an improvement in the socio-economic conditions of the population.

DIRECTION FOR FUTURE RESEARCH

It was not possible to cover all the dimensions of a social problem and this study is not an exception. The present study did not perform an elaborate analysis on unmet need for family planning among the spacers and limiters. It also could not perform analysis on male sterilization due to lack of data. However, the proposed model was not
tested completely. The present study did not look at interactions between variables, which could have affected unmet need for family planning in a different direction.

Furthermore, unmet need for family planning may affect on the number of children a man has. If they report unmet need for family planning, they might intend to regulate fertility. On the contrary, they don’t have the desired method to use, which in turn affects their fertility level and increases the number of children. This casual connection remains unexplored in this study. Due to time constraints, this study could not find out what really causes the high Exp (B) for the third indicator of availability of the family planning services. The above-mentioned gap could be the direction for future research.


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As a Junior Research Investigator of National Institute of Population Research and Training (NIPORT), I was involved with a research project “Profiles of Family Planning Program Performance in Bangladesh under the “Secondary Analysis of Bangladesh Demographic and Health Survey, 1993-94”.

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Member, Bangladesh Population Association

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