CHAPTER I

ESSAY

"It is the duty of the state to extend over the people its guardian care that those who can not or will not protect themselves, may nevertheless be protected; and that those who can and desire to do it, may have the means of doing it more easily. This right and authority should be exercised by wise laws, wisely administered; and when this is neglected, the state should be held answerable for the consequences of this neglect" Lemuel Shattack 1850

1.1 INTRODUCTION

In Pakistan, community social structure and belief systems are defined and dominated by men, which perpetuate gender imbalances and contribute to poor outcomes in family planning and reproductive health. Family planning program has assumed increasingly important role over past four decades but men's participation and circumstances have received scant attention. Traditionally, contraceptive practice has relied heavily on female sterility, IUD and oral agents taken by women, but it requires both male participation and cooperation for its successful implementation. Failure to target men in family planning interventions has weakened the impact of the program.

Due to patriarchal structures that benefit males more than females, men have often remained passive or non responsive to probing by researchers or as targets for the dissemination of family planning information. Thus little is known about men's perception of their role in family planning practice. Historically, both sociocultural perceptions and technological know-how have set the stage for the current disproportionate emphasis on females as agents for fertility regulation and infertility investigation. The overwhelming reliance on female methods has led to an assumption that contraception is for women only. Thus, there is a big organizational problem of

lack of male involvement in the program. In fact, we have ignored the fact that 'two are required to make a baby'. The spread of information about family planning is verticalized by the program through female health workers (FHWs) to females rather than taking a holistic picture of men's sociocultural and economic dominance in decision making. The family planning program has been organized to be almost entirely staffed at grass roots level by women. There is no a priori reason for assuming that women are more motivated for family planning than men (Harrison, 1989:291). Male empowerment and participation are essential elements in women's empowerment (Dr. Parmilla Sanayake, 1994:4).

Thus the contraceptive use remains low (17. 8%) even knowledge is very high (91%) and family sizes remain high due to sociocultural, political, economic and gender factors, relating mainly to lack of female control over decision on fertility. A considerable unmet need for family planning services remains, which has not been converted into effective contraceptive usage, partly because of family dynamics of male dominated society. Women, who bear most of the costs of childbearing, may want fewer children, while men, who receive most of the benefits, may want more (Robinson WC; Shah MA; Shah NM, 1981:91). "In Bangladesh, among the reasons for low contraceptive acceptance rates as opposed to a high awareness level is women's reluctance to practice family planning, they are opposed in adopting a method by their husbands" (Rahman M, 1984:119-26). Recent studies in Pakistan reveal that men are responsible for producing as many as 50 percent more children than women (Ayesha Karim Khan, 1994:8).

Thus family planning initiatives and information should move from involvement of the female alone to both sexes. Women need men as partners who understands the risks they might be exposed and strategies for their prevention. The existence of male dominance in family decisions makes it necessary to include males in family planning programs and to educate them (Roberts BJ; Griffiths W, 1969: IFPC). Study findings in regard to education and communication suggest that education programs aimed at both partners were more effective than those aimed at only one of the partners (Khan NI; Reynolds R; Haider SJ, 1973:641). A program targeted on men may achieve their support of their partner's choice to practice family planning that is a critical element for success.

"Male involvement in family planning programs has been recognized as an important strategy towards shared responsibility between men and women in reproductive decisions as well as in the prevalence of STDs and AIDS. The data shows that the type of contraceptive used is very much gender biased indicating that the burden of contraceptive use is on women. The male methods of vasectomy, withdrawal and condoms are used by fewer couples than the female methods of sterilization, pills, injectables, IUDs, vaginal barriers for most countries. No matter what the socio-economic development of the country, the responsibility of regulating reproduction seems to lie with women" (Anonymous, 1995: 12).

Therefore, we need to target men and introduce Male Healthworkers (MHWs) , supporting FHWs, as a part of strategy to behavior change toward family planning.

1. 2 LOW CONTRACEPTIVE USE & ITS IMPLICATIONS IN PAKISTAN

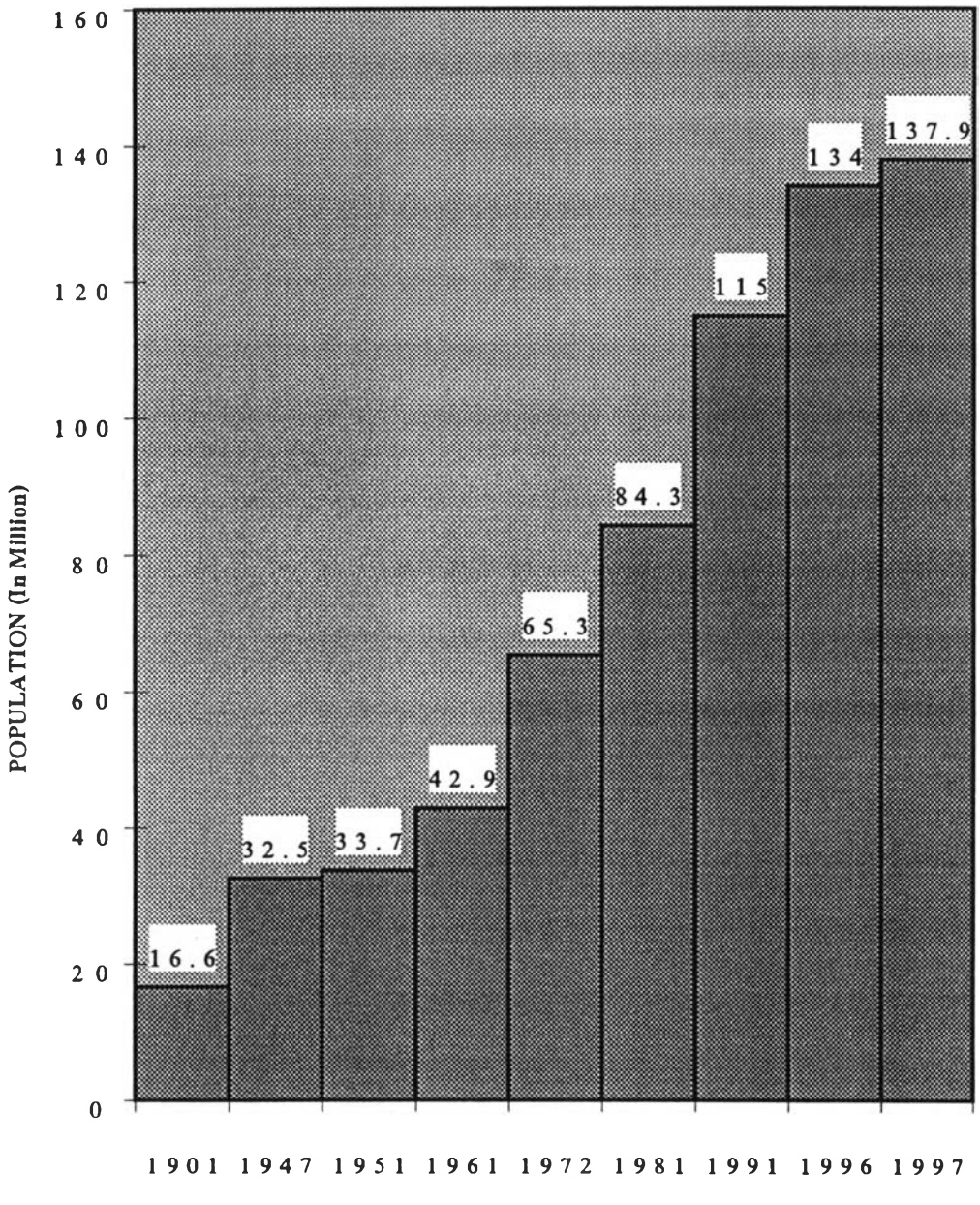
Pakistan is the 7th most populous country in the world after China, India, USSR, USA, Indonesia and Brazil. The population of Pakistan was 16.6 million in 1901; and 32.5 million in 1947, 134 million in 1996 and 137.9 million in 1997, which constitutes 2.4% of the population of the whole world (figure I), with male comprising 52.5% and the sex ratio is 107 male to 100 female. Crude Birth Rate is 36

and Total Fertility Rate is 5.1 children per women (both varying with different studies). Population Growth Rate is 2.7% (exponential, i. e., including immigrants and emigrants), and is one of the highest in the world (Table 1.1).

The population doubling time is just 25 years. And this will result in shortage of educational facilities, health services, housing units, food, living space, arable land, clean water. Further problems of unemployment, land fragmentation, import of food, environmental problems, congestion in households, overcrowding, poverty, unrest and crime will be aggravated.

The people in Pakistan, in general, are desperately poor and are experiencing high levels of mortality, morbidity and disability; and have little or no access to modern health services (55% accessibility, PDHS, 1990-91). "The South Asia region is the poorest and most illiterate region in the world. . . . more children go bed hungry every night in SouthAsia than anywhere else in the world including sub-Saharan Africa. SouthAsia is defined as Pakistan, India, Srilanka, Bangladesh, Bhutan, and Maldives. A United Nations report says "(Bangkok Post, 10 April, 1997:8). High population growth is further affecting adversely as studies suggest that population growth rate and per capita income are inversely related. (figure 1.2 & 1.3 explain the relationship between population growth rate and per capita income as comparing South Korea and Pakistan in 1950 and 1995).

FIGURE 1.1
POPULATION SIZE, PAKISTAN, 1991 1997



SOURCE: HIGH POPULATION GROWTH & ITS IMPLICATIONS IN PAKISTAN: NIPS

The characteristics of low level of human capital is emphasized by statistics on literacy rates; Pakistan has one of the lowest literacy rates (38%) in the world. Moreover there is a wide gap between male (50%) and female (25%) literacy rates. The primary school enrollment ratio is too very low (49%); 63% for male and 35% for female; and only 50% of these complete five years of primary school education. And in contrast, higher education has expanded too rapidly leading to unemployment amongst secondary school and university graduates. This major problem of unemployment is aggravated by high population growth and rapid increasing rate of urbanization. (figure 1.4 explains how unemployment has been aggravated by high population growth).

A striking feature due to high population growth rate is a large proportion of children who require food, education and health services before they will become productive. (figure 1.5 describes future requirement of Primary Schools in the country in 2020).

Rapid population growth, in addition, causes higher incidence of communicable diseases as a result of overcrowded, poor housing, high maternal mortality and morbidity, high infant mortality and poor nutrition. Such population growth rates are the product of high fertility and declining death rates (figure 1.6 is the rate of natural increase in Pakistan). Apart from nutrition , there are lack of access to safe drinking water (Population with no access to safe drinking water 40 million,); inadequate sanitation (Population with no sanitation 78 million); poor housing (population with only one room house is 68 million) and lack of reasonable quality health services according to Ministry of Population Welfare, 1996. Many diseases spread through

TABLE 1.1

Population (mid 1997)	137,906
Population growth rate exponential	2.7%
Crude birth rate	36.4/1000
Crude death rate	7.9/1000
Total fertility rate	5.1/woman
Age specific fertility rate (15-19)	90/1000
Contraceptive prevalence rate modern methods	13%
Median age at marriage	18.6 YEARS
Median birth interval	29.3 MONTHS
Life expectancy (male)	63
Life expectancy (female)	65
Infant mortality rate	75/1000 live births
Maternal mortality rate (1990)	340/100,000 live births
Sex ratio of the population	107 male: 100 female
Percentage aged 0-14	42%
Percentage aged 60+	5%
percentage aged 65+	3%
Per capita income	$ 495
human development index	0.442
population projected to 2020	247.8 million
population density	177 persons/ square km

Source: United Nations, ESCAP, 1997, Population Data Sheet, PDHS, 1990-91

contamination of food, water, or soil with human waste. Thus, an immediate attention is required to deal this burgeoning problem of high population growth. Further, short birth interval as a result of low usage of contraceptives is aggravating factors to high IMR and high MMR. Median Birth Interval in Pakistan is just 29 months and one of every three births is with interval of less than 24 months and half of these are within less than 18 months interval. "The studies suggest that child born with less than 24 months interval is at higher risk of dying (PDHS, 1990-91). Infant Mortality Rate 75/1000 livebirths in Pakistan, and one main reason is short birth interval (Table 1.1).

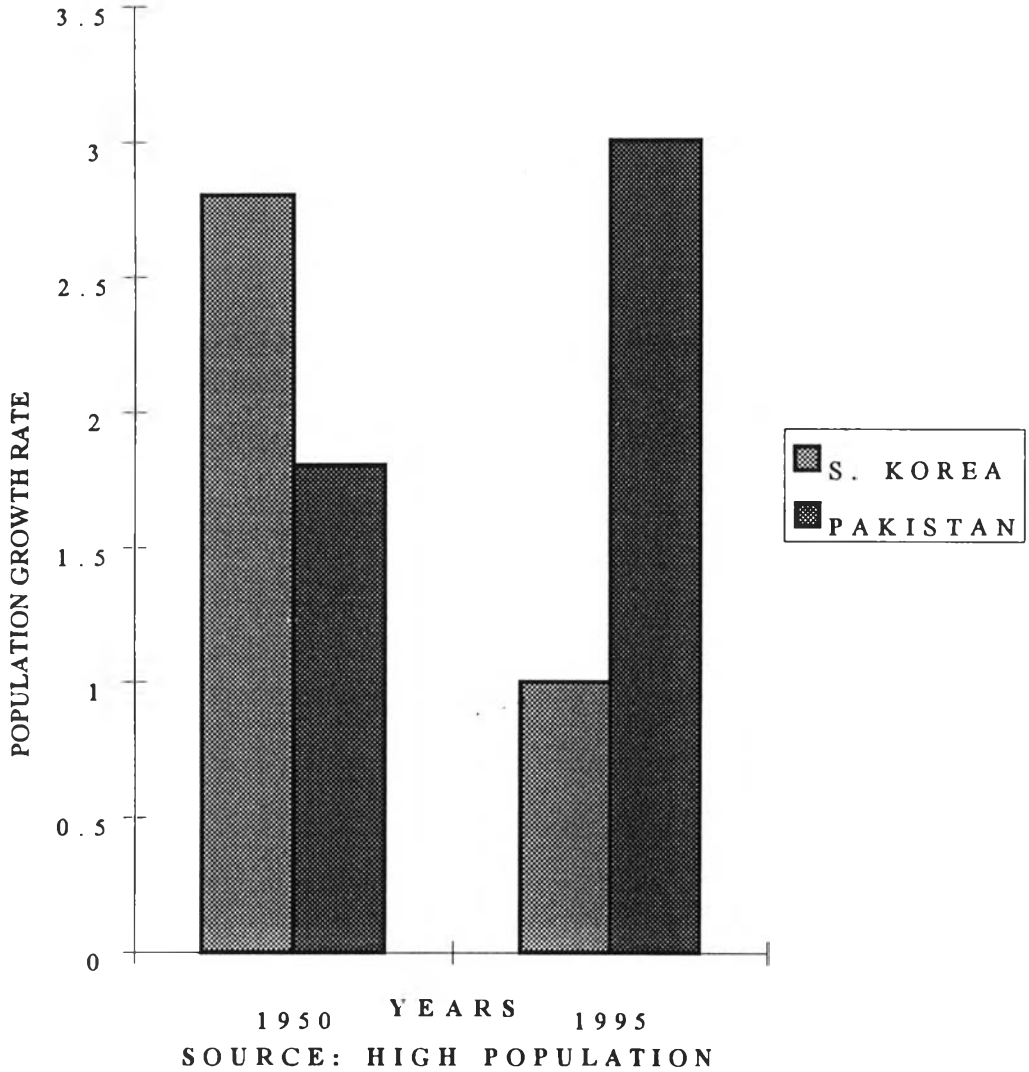
The other consequences of short birth interval is high Maternal Mortality Rate. Maternal mortality in Pakistan is 340/1000 and only 55% of women have an access to health services (Table I). The contributing factor to high MMR is the fear of risks associated with contraception. The studies suggest that 25 - 40% maternal deaths can be prevented only by avoiding unwanted pregnancies through use of family planning; and an unplanned and unwanted pregnancy carries a risk 20 times higher than those associated with contraceptive methods (Maine D; 1987:35).

1.3 NATIONAL FAMILY PLANNING PROGRAM (AN OVERVIEW)

Pakistan was a pioneer among the most populated countries in supporting and implementing Family Planning activities starting in 1950s. Concern has been expressed in successive Five Year Development Plans (1955-60 to 1993-98) about rapid population growth and provisions have been made to support a Family Planning Program to deal with this burgeoning problem. Different strategies and approaches

FIGURE 1.2

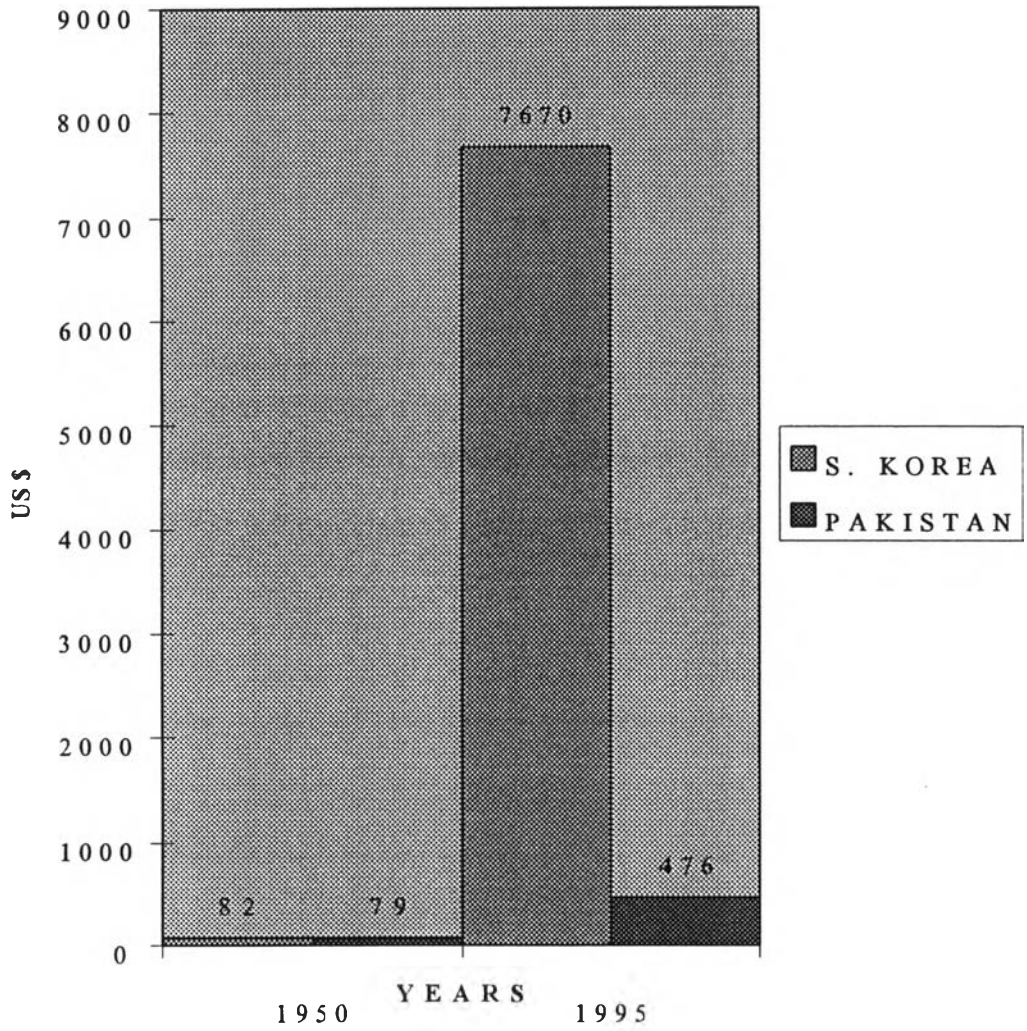
PAKISTAN AND S.KOREA POPULATION GROWTH(1950 AND 1995)



SOURCE: HIGH POPULATION GROWTH & ITS IMPLICATIONS IN PAKISTAN:NIPS

FIGURE 1.3

PER CAPITA INCOME SOUTH KOREA AND PAKISTAN (1950 AND 1995)

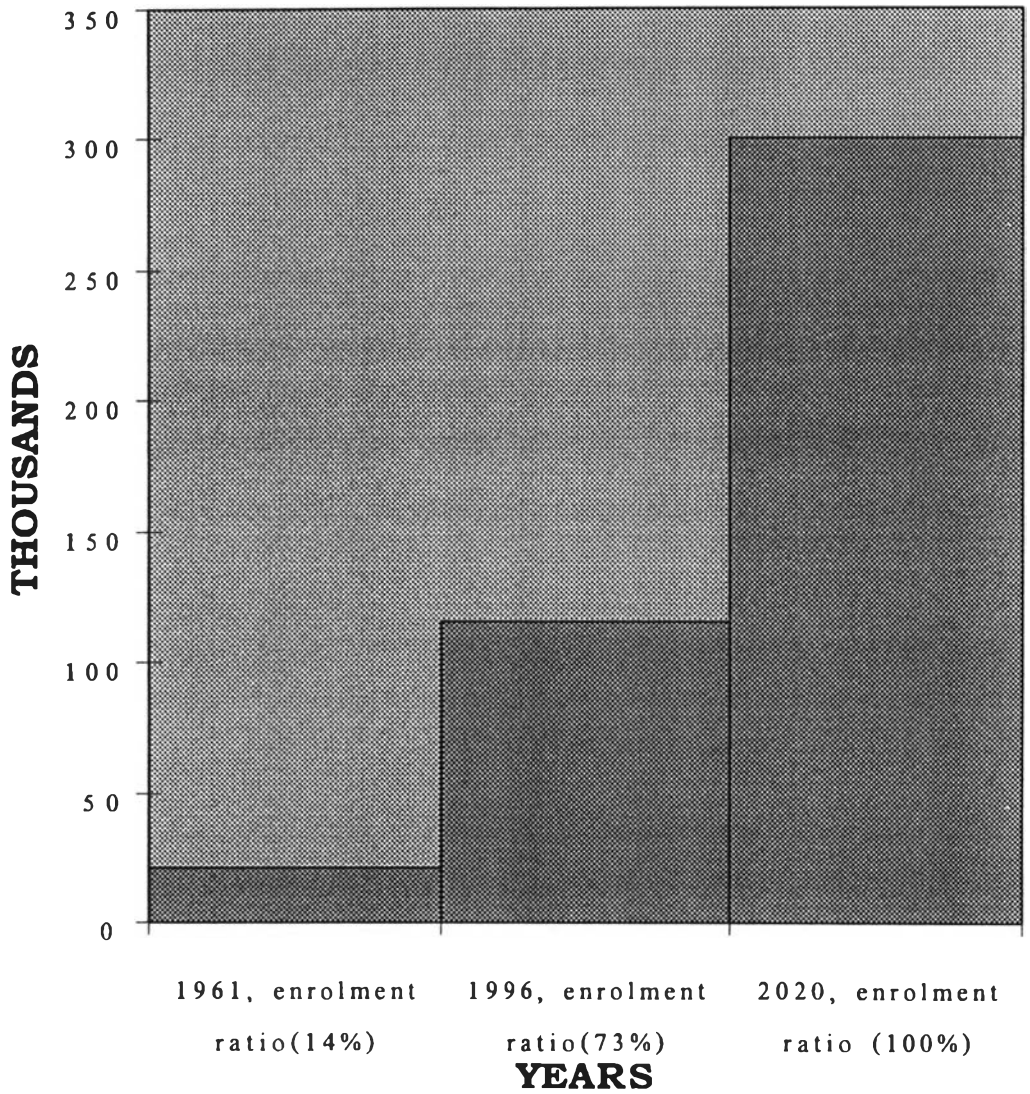


SOURCE: HIGH POPULATION GROWTH AND ITS IMPLICATIONS IN PAKISTAN: NIPS

FIGURE 1.4
EMPLOYMENT AND UNEMPLOYMENT, PAKISTAN(PERSONS IN MILLION)

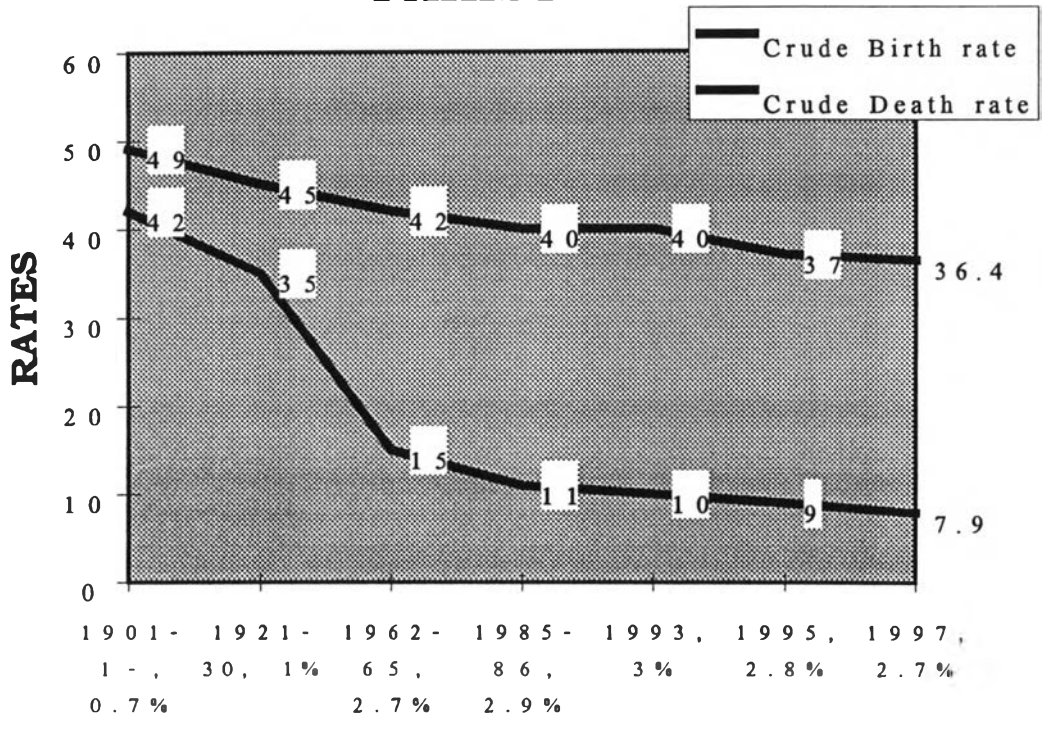
UNEMPLOYMENT
EMPLOYMENT
HIGH POPULATION GROWTH & ITS IMPLICATIONS IN PAKISTAN: NIPS

FIGURE 1.5
AVAILABILITY AND FUTURE REQUIREMENT OF PRIMARY SCHOOLS, PAKISTAN



SOURCE: HIGH POPULATION GROWTH & ITS IMPLICATIONS IN PAKISTAN: NIPS

FIGURE 1.6
RATE OF NATURAL INCREASE
PAKISTAN



SOURCE: HIGH POPULATION GROWTH & ITS IMPLICATIONS IN PAKISTAN: NIPS

have been adopted during each Plan period to promote the concept of small family norms and to encourage the use of modern methods of Family Planning. The strategies have varied in design, coverage, outreach, supervision and guidance. However, the program has not been adequately effective in providing family planning services for generation desired demand for the adoption of the contraceptives (PDHS, 1990-91. The failure of the program is to such an extent, that has created a notion that 'we can not stop now'.

Factors which are generally associated with high fertility rates worldwide also pertain to Pakistan: high illiteracy (particularly among female), poverty, high infant and child mortality rate, high maternal mortality rate, a preference for son, poor access to health facilities, low socio-economic status of woman, ignorance, conservatism, fatalism, and religiosity (Table 1.2 & Figure 1.3). These factors reinforced one another in maintaining high and stable fertility rates in the country. There are number of interrelated factors which are usually attributed to this failure.

Lack of consistency in the government commitment remained a big hurdle throughout whole life of the program. One major reason for this inconsistency is powerful ***role of religion in politics***. Only the glamour years for the program were 1965-69, when Ayyub Khan was in power. First the role of religion in his government was not significant, and second, the influence of development ideology of his time. Economic growth, modern industrialization, higher per capita incomes- these were catchwords of progress in 1960s (Ayesha Khan, 1996: 31-32). The most notorious period in the history of family planning program was 1977-88, when General Zia froze

program activities because this was not consistent with his slogan of Islamisation. The second reason for this lack of consistency is the ***role of NGOs*** as major fund donors. They (Donors) have funded the government program heavily since its inception and thus have closely nurtured the fundamental "administrative" and ***supply based approach*** towards population planning program in Pakistan that is providing such a hindrance to its success, today (Ayesha Khan, 1996:44). Thus ***ignorance of client centered approach*** lead to failure in demand creation.

The population, moreover, suffered from ***overcentralization***, a strong federal control since 1976. In 1979 UNFPA suggested provincialization as the first step in transition towards the full integration of population with health, which was already the responsibility of provinces (UNFPA, 1979:64). Provincial Councils were created for population welfare planning, with District councils as the most important implementers of the activities (Robinson et. al. 1981:109). Funding of all population activities in the government sector, however, remained part of Federal budget Annual Development Plan. Although the Government promised decentralization, it was and still it is unable to work out the modalities. One reason is that the Constitution of Pakistan declares population the responsibility of the Federal government (Ayesha Khan, 1996:42).

Over centralization of funds is also a problem for provincial population staff, who rely on the federal government to release money for even the most minor expenditure at the local level. Lack of communication within federal sectors remains a problem and equally weak are provincial-federal communication links (Ayesha Khan, 1996:44).

TABLE 1.2

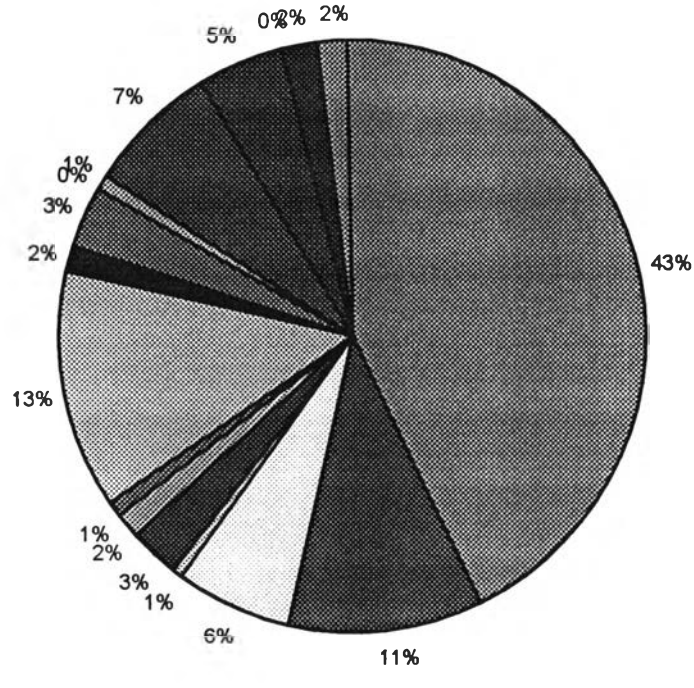
Reasons for nonuse	Percentage
Wants Children	42.7
Religion	13.2
Lack of Knowledge	10.5
Difficult to get pregnant	7.3
Husband opposed	6.4
Menopausal/had hysterectomy	4.5
Fatalistic	3.1
Worry about side effects	2.8
opposed to family planning	1.6
Don't know	1.6
Health concerns	1.5
Infrequent sex	1.0
Hard to get methods	0.8
Costs too much	0.6
Other people opposed	0.2
Inconvenient	0.2
Other	1.9
Total	100

Source: PDHS, 1990-91

FIGURE 1.7

SOURCE: NIPS

REASONS FOR NONUSE OF CONTRACEPTION AMONG CURRENTLY MARRIED WOMEN



The ongoing position of the population welfare division, since promoted to Ministry in 1989, has been that the provinces lack the political will and infrastructure to assume ownership of the program (Ministry of Health, 1994). This is partially true, given that political commitment at the provincial, district and local levels is weak for social sectors as a whole in Pakistan, a problem separate from the higher level political leadership which is more often viewed as an indicator of commitment (Ayesha Khan, 1996:44).

The lack of coordination among the employees in the same department and also among the employees of different departments leads to a number of ***managerial and administrative problems***. These problems, in terms of planning, management and evaluation, too, share the causes of ineffective family program.

The chaotic management and administration leads to ineffective training and incompetence of the workers. 'In one survey of trained dais 50% thought the IUD might go into the stomach or some other part of the body from uterus' (Harrison FC, 1989: 291).

Moreover, there is a big organizational problem of **lack of male involvement** in the program. In fact, we have ignored the fact that 'two are required to make a baby'. Therefore, all efforts have been made in past focusing female population that is only one half of the picture. But, on the other hand, if we want family planning program to arrive at a self sustainable point, we must explore, why other half of the picture remained absent from screen and how it can be viewed in its best look and

appearance. Thus, research is required to study factors that restricted male involvement in family planning and also, how male can be targeted to get best possible outcome.

1.4 WHY ARE MEN NOT INVOLVED IN FAMILY PLANNING?

"Some men see things as they are and ask 'why'?
I dream things that never were and ask 'why not'?

Robert F Kennedy

Among the reasons for lack of male focus are two facts; first, the woman is the bearer of children and thus regarded as a more 'natural' focus ; and second, more female than male methods are available.

Traditionally Family Planning Programs in Pakistan, have been female focused and female centered. A majority of methods provided by Programs have been for females; and knowledge and attitudes of women have been given more weight in several international studies. Most data concerning family planning have focused on the study of contraceptive knowledge and adoption amongst women. The findings point to a disproportionate emphasis on methods that target the female partner. The female bias in the promotion of family planning program is an issue in the most Asian countries , as men play a dominant role in deciding whether their wives can initiate the use of contraceptives(Mbizvo and Bassett, 1996:87). Since men play a predominant role in family decision-making, therefore, they need to be educated and motivated to use family planning. (Danforth N, 1993:1).

Moreover, Family planning providers have the preconceived notion that men will not be interested in family planning (Danforth N, 1993:1). Family planning providers are biased against serving men; this bias must be eliminated. Most family planning programs are targeted to women and withhold information and services from men, but recent studies have found 65-90% of surveyed men approve of family planning for birth spacing or limiting (Danforth N, 1993:1). The research shows that rural Punjabi men are neither unconcerned about their families' well-being nor irresponsible. These men have simply not been educated adequately, or at all, about the full range of available contraceptive methods (Agha S, 1992).

Men who are educated , who marry at a later age, who are monogamous, who discuss family size with their wife, and who plan to rely upon investments or savings, instead of upon their children, for old age support were, however, significantly more likely than other men to prefer small families and to have fewer children (Donovan P, 1995:40). These findings indicate a need to target information and awareness program at men with the goal of influencing their attitudes about reproductive matters and motivating couples to have fewer children.

In addition, it is often assumed that a woman would be more amenable to family planning messages and would be accessible to family planning providers because of her contact with health services dealing with reproductive health. Men have therefore left the responsibility for family planning to their wives and partners. Thus, family planning program stands to benefit from a deeper understanding and insight into male

reproductive and sexual behavior; and male education on social contexts of high fertility risks to both men and women.

1.5 WHY SHOULD MEN BE INVOLVED IN FAMILY PLANNING?

Traditionally in Pakistan, family planning decisions remain in the male domain, regarding their reproductive health. As consumers of health services and family planning techniques women often are more accessible to health education and researchers than men. Family planning should be a dual commitment, but in Pakistan it seems as wholly the woman's responsibility. She bears the burden not only of pregnancy and childbirth but also threats from excessive childbearing, responsibilities for contraception, infertility investigations and often undiagnosed STDs.

There is a misconception at community level that label high fertility as a female disease; and fertility regulation as the problem in the female preserve. The men are forgotten 50 percent of the population and perhaps because they can not conceive or carry a pregnancy. However, as loci of behavior change in light of fertility control, women may have the most limited options. Indeed, it is probable that women are unlikely to use family planning without the permission of their husbands, because even the Islamic scholars, who permit the use of modern birth control methods, stress that it should be used only with the mutual consent of husband and wife. (Harrison, 1989:291). Thus the prescriptions that promote behavioral change must take into account women's constraints.

In Pakistan, in the 90s, still, father knows best. It is father who gets the best and the largest portion of meat, father whose cravings determine the day's menu, father who makes major decisions, father whose wishes are supreme and who is the unshared ruler of the home kingdom.

Gender is an important pointer to vulnerability. "An Amnesty International Report dated 10 June, 1997 states that torture was common in prisons, women were discriminated against and court imposed punishments were often cruel and in-human. Torture including rape is wide spread in Pakistan" (Bangkok Post, 11 June, 1997:6). Women are found disproportionately amongst the most vulnerable population groups. They tend to be poorer than men on average, to have less access to income earning opportunities, other resources including health care and be more dependent on others for their long term security (Hillary Standing, 1997:2). Due to high illiteracy rate and pressure from husbands, most women do not have access to family planning services (Anonymous, 1990). Thus even knowledge is high, contraceptive use remains low.

In Pakistan culture tend to be patriarchal male dominated and authoritarian. Male dominate in each and every sphere of life including Politics, Cabinet, Parliament, Army, Police, Airforce and all other departments like Sports. Women are subservient to men (Shah A, 1994: 118). According to PDHS 1990-91, in Pakistan, 93 percent of males serve as household head as compared to only 7 percent headed by female. Most of people who practice family planning are women, the final decision lies in the hands of men, their husbands, since they (the men) are the head of the family. The positive involvement of males in family planning programs is very small as compared

with their noninvolvement. Therefore it is obvious that men need to be motivated as intensively as possible. Campaigns on having a small family which previously have been directed towards women should and will in the future, be more positively extended to include men (Dr. Kortono Muhammad Honorary secretary IPPA, 1982).

> "Men are the dominant decision makers in urban Nigerian families, including in the matters relating to reproduction and family size. The country's male dominant and patrilineal traditions encourage large families. 88% of surveyed men and 78% of surveyed women reported men's views to be more influential than women's views in family decisions. Men and women agreed that men generally decide whether the couple will have sexual relations, the duration of postpartum abstinence and whether the couple will practice family planning (Donovan P, 1995:39). "

The norm in Pakistan is for women to stay home and take care of house and children. Social, political, and religious factors constrain women's participation in society outside the household (Cernada GP; Rob AK, 1994:105). It is not common for women to join labor market and their mobility is often restricted to such an extent that only 25 percent women in PDHS, 1990-91 stated that they could go alone to visit a hospital for their illness. In most countries, users of oral contraceptives obtain their own supplies. This is not true, however, in Pakistan, where women generally do not venture outside the area of their homes. Family planning researchers and managers should give more attention to husbands in countries like Pakistan where men dominate communication networks.

Further "Purdah" (veil) system in Pakistan, aggravates the restriction toward mobility of women. Implication of this behavior is that men, including husbands, generally dominate in purchasing household supplies, including supplies of oral pills (Davies J; Mitra SN, Schellstede WP, 1987:167). In Muslim societies with the purdah system,

social marketing programs should consider the importance of husbands as providers and as instructors for their wives on proper pill use (Anonymous, 1987:112).

> More and more men are convincing their wives to use family planning in Bangladesh. In this conservative, Moslem country, women are not allowed to leave the homes so husbands must go to buy methods especially rural areas. >70% of women who use oral contraceptives, IUDs, or condoms, report that their husbands obtain these methods for them (Ahsan SB, 1992:18).

The working status of the women, too, is low in Pakistan. Moreover, opportunity for employment is limited for the females. According to PDHS 1990-91, only 16. 8 percent of women are currently working in Pakistan. The access of women and girls to household resources for health expenditure in both rural and urban areas has been found in many instances to be less than that of men and boys (Hillary Standing, 1997: 2). The female employment is inversely related to fertility and positively related to contraceptive use. Employment delays marriage and increases the probability of women remaining single, thus reducing fertility. The analysis indicates that, in general, women who worked at all before marriage, married somewhat later than women, who did not; whereas higher level occupations, work outside home and work for cash were all related to increases in age at marriage (Singh S; Samara R, 1996:155).

A working wife has more status with her husband, and the resultant improved spousal communication leads to more contraceptive use (Chaudhry RH, 1983:101). Women's autonomy measured by control of income and participation in household decisions, is a better determinant of fertility behavior among the Yoruba women than traditional indicators such as education and employment (Kritz MM; Gurak DT, 1991:6). Cashwork and control over earnings were significant determinants of the likelihood of

spousal communication about family planning (Gage AJ, 1995:276). The most direct determinants of demand for contraception were wife's land ownership and contribution to household expenses. The role played by economic control may surpass other standard socio-economic indicators (Kritz MM; Gurak DT; Fapohunda B, 1992:6). Moreover, the satisfactions of outside employment can substitute for those of child rearing. And every additional child increases the "opportunity cost" (income lost) of a working mother. Furthermore, a working women do not have to rely on their children for support in their old age. Thus, low working status of women is too a constraint on contraceptive use in Pakistan.

> "Using data from various rural and urban surveys of women in Bangladesh (mostly in Dhaka) and data from the 1961 Bangladesh Population Census, the author finds that fertility is reduced and contraceptive use increases for poor and illiterate women if they work outside the home, but employment has no effect on fertility for higher educated women, who have comparatively fewer children to begin with. In Java, Indonesia, it was found that poor working women have the lowest fertility compared to any other higher socioeconomic group. In Thailand, too, it was found that women who worked outside the home and who had modern values had significantly fewer children than other women (Chaudhry RH, 1983:100). "

Further, a heavy social support is given to early marriages. One of the main reason is that woman has no role in making decision about her marriage and it is her brother or father who decides when and with whom she will marry. The likelihood of spousal communication about family planning and modern contraceptive use is significantly higher among women who exercised complete control over selection of partner than among those with arranged marriages (Gage, 1995:264). The median age of marriage in Pakistan is 18. 6 years (Table 1.1). A social concern is expressed if the wife does not become pregnant during the first year of marriage. The relationship between maternal age and mortality in the Pakistan Labor force and Migration Survey (PLM) confirms that children of the youngest mothers experienced the high rates of infant

mortality (Sathar, 1985). Women are a reproductive asset, for the extended family encourages numerous progeny as a way to further extend the family, secure more labor which can be exploited, and assure old age insurance (Inayatullah A, 1964: IPPF, Singapore). Thus, an early marriaged women has little power to decide about birthspacing and family size just like her time and partner of marriage.

Moreover, females exhibit an earlier transition than males to widowhood or to being divorced or separated. The finding is consistent with the cultural norm which permit remarriage of widowed or divorced men but discourages the remarriage of women (PDHS, 1990-91:24). Thus, the remarriage, culturally allowed to men, is another factor which attracts attention to target men, even more than women.

Further, studies in PDHS, 1990-91, indicate a significant discrimination among men and women about their educational status. 43 percent of males and 68 percent of females have never attended school. Overall, 30 percent of males and 20 percent of females have attended only primary school, while 16 percent of males and 7 percent of females have reported to have reached secondary school and higher education. On average males have completed 3. 2 years of schooling, whereas females have completed only 1.6 years of schooling. Men are 50 percent more likely to attend secondary school, twice more likely to attend middle school and 2.3 times more likely to attend secondary school or higher education. The data indicates that males receive much more education than females. 79 percent of women have no education, 14 percent have only primary or middle education, while only 7 percent have secondary or higher education.

The sex differential in education attainment continues to be significant for all ages with little indication that the gap is decreasing except in the youngest group. The relationship between the number of girls for 100 boys enrolled in secondary school and the percentage of women married before 20 is significant and the correlation coefficient is -0.68, indicating that greater equality between males and females - at least as it pertains to formal schooling - is strongly associated with a low prevalence of early marriage among women (Singh S; Samara R, 1996:155). Thus, the husbands, being more educated, are more likely to respond better than women to an education program targeted on them. Thus the low education status of women results in constraints to women's decision making and using contraceptives.

Husband's education has a negative effect on both the husband's and the wife's wanting more children (Khan MA; Sirajeldin I, 1977:493). Discussions on family size preferences have been shown to take place in families where the male partner had more years of schooling compared with less educated men. Educational attainment and discussion of family size was significant (p=0. 014) for males, but not for females (Adamchak; Mbizvo, 1991). Thus, men inclusion in education program may motivate them to discuss family size and birth spacing.

> "In a study in Ghana, (Ezeh, 1993) concluded
> that spousal influence , rather than being mutual or reciprocal was an exclusive right exercised only by the husband. A young woman in study reported ' when I wanted to do family planning my husband did not allow me, so I did not do it. A man further commented ' in my view, the woman has no legitimate right . . . . . it is God who grants children, the woman has no right to choose the number of children she prefers . . . . . it is you the man, who decides to have sex with her' ".

In PDHS 1990-91, wives were somewhat less knowledgeable about their spouse's opinion of family planning than were husbands. Specifically, husbands are more favorable toward family planning than their wives believe. In one third of the cases in which the wife thinks her husband disapproves, the husband actually approves. Under such circumstances, improved communication between spouses may engender more favorable attitudes toward family planning overall.

> " Some recent research in Africa shows that many men already have a positive attitude towards family planning, but there is poor or no positive communication between husband and wife about fertility and sexuality (Hawkins K, 1992)".

> "4 reports published by Demographic and Health Surveys (DHS) include information from husbands of the wives interviewed in the main part of the survey. All are from Africa--Burundi (1987), Ghana (1988), Kenya (1988) and Mali (1987). These surveys of husbands indicate the importance of programs that work to improve communication between spouses about family planning. In particular, they show a positive association between contraceptive prevalence and husband and wife communication about family planning. Women may, however, underestimate their husbands interest or participation in family planning. Or men could be overstating the use of male methods. These DHS husband surveys suggest that programs aimed at both men and women should encourage more and better communication between spouses about family planning. (Hardy Cleaveland K, 1992 :13).

Analysis of different studies conclude that there is strong relationship between contraceptive use and interspousal communication. Husband-wife communication about family planning has been identified as the major source of motivation for contraceptive use in Pakistan (Pakistan Development Review, 1994:683). The communicating spouses had a higher level of contraceptive use at every level of age, education, income, actual and desired family size, as well as among the occupational, religious and residential groups (Bhatia JC; Neumann AK, 1980:29); and the mutual recognition of approval is a strong positive force in the adoption of family planning.

Similarly mutual recognition of disapproval is factor that discourages the use of family planning. In PDHS, 26% women reported that they had discussed contraception with their spouse at least once during the year. Only 5% of the couples discussed family planning more than twice, 21% discussed once or twice, while 74% have never discussed. Gender inequality hindered women from negotiating the use of condoms for safer sex (Gordon G,1992:45). Thus in order to cover the reproductive and sexual needs of the couple more appropriately, an increased participation and sharing of responsibility by men in actual practice of Family Planning required.

> "A significant correlation was found between the variables for contraceptive use and to motivation to avoid pregnancy among women who perceive that their husbands were supportive ($p<0.001$). The measure of husband's influence was highly significant in its relationship to discontinuation. The data suggests that the husband's influence on contraceptive use is of major significance in contraceptive continuation among urban Bangladeshi women
>
> (Chaudry D; Harvey SM, 1994). "

Therefore, in Pakistan, the female partner does not make a decision to use contraceptives in a vacuum, but she adopts a method after consultation with her male partner; the IUD is sometimes a male choice and a means by which he can pass the action of contraception to his wife and monitor her behavior at the same time (Angin Z; Shorter FC, 1994:102). In societies like Pakistan, where traditional patterns of interaction may discourage verbal expression of one's likes and dislikes on intimate sexual matters, couples generally have a pretty good idea of how the partner feels about the major behavior such as contraceptive use. Such perceptions condition their behavior. Consequently, a woman is unlikely to adopt a contraceptive method or continue its use for extended period of time in defiance of partner's opposition or disapproval.

In terms of decision making regarding use of contraceptives, women in PDHS (1991) and PCPS (1995), reported that men were more often responsible for the decision to use contraception than the women themselves, although women were far more likely to actually obtain information and use contraceptives. In Pakistan, in PDHS, 1990-91, 65.7 percent of men reported having knowledge of female sterilization against only 9.3 percent with unprompted knowledge of male sterilization. The studies also demonstrate that marriage was practically universal and whereas contraceptive prevalence rate was high, in the majority of the cases men had responsibility for deciding on contraceptive adoption and family size. The Planned Parenthood Association of Zambia (PPAZ) thinks that if males become more knowledgeable about family planning , the population growth would slow down (Chirambo K,1992:16). A program that targets men as a means for reaching and altering their wive's reproductive behavior will far much better than one that targets women as a means for reaching their husbands (Ezeh, 1993:173).

1.6 WHAT ARE MEN'S PERCEPTIONS?

Despite growing recognition male participation in family planning has remained modest. Therefore, question arises, 'what is it that makes most men behave the way they do with those closest to their hearts- their wives and children? The answer is ' it is the untaught informal lesson that percolates through the senses when a mother cuts a slice of cake in two and hands a larger piece to her son and gives her daughter the smaller one. It is the same lesson rephrased, that a girl must help in the kitchen while her brother goes out to play with the boys. The massage is passed on spelling a

'truth': women are only home tenders and thus second class. Changing this perception in obvious ways is feared by men, that it will change the power of dynamics of marriage. Small scale studies have revealed positive attitudes, high knowledge levels and low usage levels among men (Hulton L; Falkingham J 1996:99). Thus future research should focus on why male knowledge is so high and what motivates male contraceptive use.

One obstacle to reducing fertility in Pakistan is that men feel they must prove their virility by producing sons and the more sons the more virile man is. In fact, the husbands, especially uneducated husbands, do not allow their wives to use contraceptives. According to many studies, many more women would use them than presently do if their husbands would approve (FPAP, 1989). Thus, men need to know that the most irrefutable proof of a man's virility is not his ability to have children but his capacity and his commitment to raising them. There is no comparison between a single act of intimacy leading to conception, and the entire life of attention, sustenance, protection, education, guidance and dedication that is required to raise the children.

Tradition of polygyny, further, adversely impinges the situation . Polygyny is legal in Pakistan, although according to Muslim Family Laws Ordinance promulgated in 1961, the husband needs to obtain written permission from his first wife to marry a second wife (PDHS, 1990-91: 91). Family planning could not gain headway as long as children, and especially sons are considered a primary sign of wealth, virility and insurance of future. Under these circumstances, if a woman resists giving births to the

number of sons a man wants, he might beat her until she agrees or he might marry someone else who will satisfy for his wish for certain number of children.

Men consistently determine what is consistent with religion; they are usually traditional in their views. Fears are common: fear of supernatural punishment, fear of social stigma, fear of contraceptive side effects and economic loss, and uncertainty. In bridging the gap between beliefs and behavior, interim solutions are evasion (men ignoring their wife's pill use), conformity and secrecy (Schuler SR; Hashemi SM, 1992). Thus they need to know new norms , at present, are: contraception/sterilization is consistence with Islam and it is sinful to bring children into the world and not provide for them.

Moreover, being household head, men may want more children, preferably son to share their financial responsibilities regardless of the consequences of short birth interval and large family size. To the extent that men exert their influence over their wives, may nevertheless resist actual use of contraceptives, if neglected in the same way, as a result of their desire for additional children and others. About 43% disapprove family planning in PDHS, 1990-91. Thus, men need to recall that each and every effort to have a son, has an equal biological chance to have a daughter and therefore, they need to recall the economic loss as Dowry if a daughter is born instead.

Men fear vasectomy because they perceive it to cause impotence. The overall increase in the contraceptive practice has been accomplished mainly through the use

of female methods. The data suggests from PDHS, 1990-91 and PCPS, 1994-95 the most prevalent method of contraception is female sterilization (5 percent) as compared to the least prevalent, almost zero, male sterilization (Table 1.3, 1.4 & 1.5).

The overwhelming difference in predominance of female over male sterilization is increasing rapidly. Besides some men prefer their wives be sterilized rather than themselves because if men lose all their children they can have other children with other wives. The urban population seemed supportive of male contraceptive use in general. However, certain factors interplay that prevent men from assuming responsibility toward actual male method use, even when they approve and support of spacing and limiting family size. This points to an unmet need for information services for men. Considerable education to counter this myth is needed to increase the number of vasectomies.

Male sterilization is surgically much simpler, less expensive and has less side effects than female sterilization. Further, they can enjoy sex better because there is no fear of having any more children. The discomfort associated with the use of condoms, their unreliability in providing protection from pregnancy, together with misconceptions and perceptions relating to the fear of losing energy and productivity from using condoms and from being vasectomised, were reported (Jahan SA; Thwin AA; Nasreen S; Ahsan RI, 1996:5). The evidence from service statistics further reveals that the low prevalence of male methods is due to small number of entrants to

TABLE 1.3

HUSBAND'S KNOWLEDGE ABOUT CONTRACEPTIVES, SOURCE, EVER USE AND CURRENT USE

Contraceptive method	Know any method	know a source	Ever used	Currently using
Any method	79.3	65.1	24.7	15.1
Any modern method	77.7	62.4	18.2	10.1
Pill	54.9	37.6	4.6	0.8
IUD	28.6	20.9	2.9	1.4
Injection	50.0	36.9	2.9	0.5
Vaginal method	12.6	10.4	0.4	--
Condom	58.8	50.1	12.1	3.6
Female sterilization	65.7	48.6	4.0	3.8
Male sterilization	31.7	22.7	0.1	---
Any traditional method	49.4	NA	15.7	5.0
Periodic abstinence	38.9	27.7	11.7	3.2
Withdrawal	39.9	NA	8.3	1.7
Other	1.6	NA	0.3	0.2

Source: PDHS, 1990-91

TABLE 1.4

WIVE'S KNOWLEDGE ABOUT CONTRACEPTIVES, SOURCE, EVER USE AND CURRENT USE

Contraceptive method	Know any method	know a source	Ever used	Currently using
Any method	90.7		28.0	17.8
Any modern method	86.2	75.5	22.6	12.6
Pill	72.7	53.1	5.8	0.7
IUD	73.4	56.8	5.4	2.1
Injection	80.5	59.9	5.3	1.0
Vaginal method	9.0	6.3	0.7	--
Condom	46.0	30.1	22.6	3.7
Female sterilization	86.2	75.5	5.0	5.0
Male sterilization	15.4	10.9	0.0	---
Any traditional method	49.4	NA	10.8	5.2
Periodic abstinence	22.3	27.7	3.2	1.0
Withdrawal	28.5	NA	9.0	4.2
Other	4.3	2.8	0.3	0.0

Source: PDHS, 1990-91

TABLE 1.5

PREFERRED CONTRACEPTIVE METHOD BY WHO INTEND TO USE IN FUTURE

Preferred method	Female	Male
Pill	13.0	7.7
IUD	6.8	0.9
Injection	15.7	13.7
Vaginal method	0.2	--
Condom	9.5	19.4
Female sterilization	17.1	20.0
Periodic abstinence	2.1	9.2
Withdrawal	1.9	3.9
Other	7.6	4.2
Missing	25.9	21.0

Source:PDHS, 1990-91

family planning program. Thus the poor utilization of male sterilization appears to be mere a result of neglect especially by planners and administrators.

> "(McGinn, et. al, 1989) states -
> The Ministry of Health and Social Welfare in Burkina Faso believes that men are open to learning about using modern contraceptives but have concerns about family planning. They are reported to fear losing their children to all to familiar ravages of disease. They fear the new drugs and devices which, according to them are reputed to harm their users and fear also that their use may change the balance of social control between men and women. "

In addition to the broad social, economic and cultural factors that discourage men from participating in family planning or encouraging their wives to do the same, they may express their concern and worries that their wives would become promiscuous if they could prevent pregnancy. More generally, they may think contraception would allow women to assert a new form of control over their bodies and hence change the power dynamics of marriage. Their suspicion can serve a strong tool to shift the burden of contraception from female methods toward male methods, especially vasectomy.

Another problem faced as a result of lack of knowledge is that term 'family planning' is universally equated with having no more children in the future. What is very important is that non permanent contraceptive methods were also thought to bring an end to childbearing. The majority of people were not aware of a way of increasing the interval between children (Agha, 1992:6).

So men need to be exposed to and involved in the program. Often the demand for a male child leads to a large family size and family size decisions are made by husbands who often have erroneous beliefs about contraception (Qureshi MS, 1983:247).

Although attitudes toward family planning were, in general, very positive among men who participated in 4 focus groups, it was evident that many of them were misinformed about contraception. Many men expressed fears about the safety and permanence of modern methods. In addition, some men perceived that contraceptive use by women would threaten their fidelity in marriage (McGinn T; Bamba A; Balma M, 1989:95). Thus, their involvement in family planning program will help to change their attitude and omit their erroneous beliefs.

Men are far from being a monolithic group opposed to family planning programs (Green CP, 1991:3). It is even possible to argue that men are likely to be more susceptible to the small family norm than women, because men are more concerned with the economic strain of supporting large families (Harrison, 199:291). The economic reasons were those most often given for not having children (Zaidi WH, 1968:47). "The economic and socio-psychological costs were more important for the men" (Baum HM, 1977:173). The decline in male economic responsibility for children may affect the use of Withdrawal, making its use more likely in the nuclear family where a father is financially responsible (Rogow D; Horowitz S, 1995: 153). Therefore, with the cost of living rising sharply, men see that a large family is difficult to afford and want to limit the number of children they have.

> "As these notes show, men are implicated in the matters of women's reproductive health, they do take responsibilities in the ways that this culture understands, and women are often partners in persuading them to do so. Limits on the number of children are as much a male concern as female concern. The principle of the program of action that these matters should be the exclusive concern of women is simply not accepted. Public policy and services must address both parties and find a way of accepting male as well as female determination of the courses of action that affect reproductive health of both parties *(Angin Z; Shorter FC, 1994: 103)*".

In almost all mammals, the male plays the role of a lover. From the apes to antelopes, fathers abandon their mate after conception, leaving mothers to feed, protect and guide her babies. But humans are different. From the very beginning, the male has tended to stay with his mate, to care, to defend and to nurture his offspring. Male participation in family is one primary characteristic of human species, the cornerstone of our civilization. Recent findings indicate that men are often much more interested in and concerned about their partner's health and well being of their families than most people realize, and cooperate with their wives or partners in using contraception (Population Reference Bureau, 1994:7).

Thus men need to be educated adequately, how large family size and short birth interval are affecting the health of their wives and children. The Planned Parenthood Association of Zambia (PPAZ) aims programs at men in order to expand their participation and nurture their influence in family planning matters. Family planning specialists in Zambia foresee an increase in male support of family planning as they realize the difficulty of supporting large families during the economic crisis (Population Services International, 1993).

Moreover, HIV has increased male concern about sexual health such that the level of condom use has increased everywhere (Danforth N,1993:1). The fact is that none of the female controlled contraceptive methods are thought to offer any protection against HIV (Hulton & Falkingham, 1996:91). Thus there may be tremendous demand from men for information about contraception and interest in taking an active part in planning their families.

Furthermore, sexually active males tended to favor family planning (De Vries JA, 1974:106); that means, who are in more need are more likely to respond. The extramarital contacts is another major reason which attracts attention to male involvement in family planning. The male/female ratio in Pakistan is 107 male : 100 female that is the lowest one in the world. Those 30% of men who do use condoms are more likely to use them with their girlfriends or women with whom they are unfamiliar. So they are not using them for family planning purposes (Chirambo K,1992:17). Thus men's knowledge about contraceptives (condoms), may be due to sexual reasons, stands to support family planning program through an education program for limiting family size and birth spacing.

All this while, it has been known that decision to use contraception is likely to be influenced by the male partner in several different ways: it may be made by him, strongly supported by him, tacitly encouraged by him, or overtly resisted by him. Support by men is indeed central to entire process of contraceptive use by the couple: adoption, continuation, discontinuation and readopting- all of which are important elements of maximizing the sustainability of the Program. Needless to say that in case of male methods his role becomes even more central. Thus, insight into factors shaping male behavior towards family planning should facilitate the design of strategies which promote their compliance. While the care of small children is a matter for women, the actual begetting of children or, rather, not begetting them, is a matter for men: just as husbands are expected to be ones to initiate sexual activity, so are they expected to take charge of contraception (Santow 1993:779,782).

1.7 PAST EXPERIENCES OF MALE INVOLVEMENT

As part of its family planning program, the government of Pakistan initiated a ***Continuous Motivation System (CMS)*** in 1973. In this system, the country was divided into "circles" of 60-1000,000 persons each. A Population Planning Officer was incharge of each circle and supervised 6 motivator teams made up of 1 male and 1female motivator. The 7000 motivators had little success, partly because most of them were young, unmarried, and nonresident in their areas of service (Goraya KA, 1979:177). Inadequate training and supervision and inadequate supplies of contraceptives resulted in an ineffective program (Reynolds J, 1987:2). The field workers, especially males, showed an appalling lack of knowledge of contraception and were vulnerable to corruption (Harrison FC, 1989:294) . Thus CMS was never implemented as planned; it failed in a sense before were put to test (Ayesha Khan 1996:37).

The second experience was ***Mardan Project***. Mardan, Pakistan, is a city of 270,000 in the NWFP. The project was launched in 1988 and executed by the Urban Community Development Council (UCDC) of Mardan. The UCDC project had 2 goals: sensitize and inform men about the benefits of birth spacing and family size limitation; and promote family planning practice by making information and contraceptive supplies available through household distribution, community clinics, and referral (Kamal I; Flower C, 1991:17). Male motivation played an essential role in creating awareness of and defusing organized opposition to family planning in the community (Spielman E, 1993:8). In 4 years, contraceptive prevalence among married couples rose from 9% to 21% (Finger WR, 1992:8-9). The successes of this

project attest to the potential for men to be effectively mobilized to promote and provide, as well as use, family planning (Population Reference Bureau (PRB), 1993:4). Thus the similar kind of projects may be implemented in other provinces like Punjab but with further improvement in the form of prior sensitization and motivation of the workers themselves.

1.8 HOW SHOULD MEN BE INVOLVED?

The challenge of future research may be to demonstrate how men from all socioeconomic levels can be included in information, education , and communication (IEC) programs that will have a positive impact. To integrate men in the program, policy makers need to be made aware of the need for male involvement in family planning and motivated to act. Common people need to be approached and involved in relevant conferences and workshops, communities need to be involved in the program, and efforts must be made to change men's behavior.

> Rimon JG 2d; Tweedie I, 1994, in a study conclude that IEC programs are needed to increase male involvement in family planning. Men must be encouraged not only to use condoms or have a vasectomy but to support their partner's use of family planning and to call for development of male related programs. Too often, men have been vilified by family planning programs. In many cases, the male stereotype presented by Family Planning Clinics acts as a barrier for male involvement and reduces the accessibility of these Clinics for men. In fact, the data on men and family planning are scarce, but it is known that men want more information about contraception and family planning that they highly approve of family planning and that contraceptive prevalence is positively affected by husband-wife communication about family planning. In fact, because of lack of spousal communication about family planning, many wives are unaware that their husbands approve of family planning. Examples of creative IEC responses to the challenge of increasing male involvement include use of community forums for men in Bangladesh to encourage open discussions on the topic, the mobilization of male opinion leaders in Ghana and in Egypt to endorse the use of family planning, and a media campaign in Brazil to promote vasectomy. To continue to improve male

> involvement we must 1) improve the understanding of male needs through research 2) position male involvement beyond the "irresponsible and uncaring" segment of the population 3) increase spousal communication 4) increase access to services 5) improve the image of male contraceptive methods 6) mobilize male opinion leaders 7) encourage open discussion among men.

Education is the key to breaking the mold of stereotyping. If education can put a woman into pilot's seat or send her into space or enable her to discuss nuclear physics at an international seminar, then education can free men from the inhibitions that restrict their emotions about their families. To increase in male awareness of family planning will be more effective by introducing education through male workers or promoters and identifying male community networks as targets. Men's awareness can make a big difference to the success of the family planning program.

Communication with and among men about family planning has proven to be crucial in promoting male involvement and then, further, in improving contraceptive use among both men and women.

> Cernada EC; Roshan M; Kayani FK, 1994 state that
> Sterilized men were older and better educated, had more children and a higher income, and were more likely to have a wife who works. Even though the husbands were responsible for family planning they had not been more active because most family planning methods are female methods. Most men noted that health and education of children and wives are the most important subjects for spousal communication. For all topics, sterilized men were more likely to talk with their wives than ever or never users. 75% of never users never discussed family planning with their wife. Sterilized and ever users were more familiar with female methods than never users (75% vs 33%). Key sources for knowledge on contraceptives, even vasectomy, were relatives, friends and neighbors. Only 10% men were against family planning. Most sterilized men and their wives are happy about vasectomy. More sterilized men had counseled other men about vasectomy. 33. 8% of sterilized men believe that Islam allows family planning compared to 28. 5% of ever users and 18.8% of never users.

> "(Ahsan, 1992) states that
> In Bangladesh a Project to introduce Norplant attempted to include men in counseling process . Preliminary findings suggest that continuation rates at 24 months were significantly higher for women whose husbands were counseled, compared with women whose husbands were not"

The Pakistani men may be reluctant to obtain contraceptives from hospitals, chemists, or clinics. On the other hand, they may feel comfortable selling and buying contraceptives to and from men. The most successful programs were those whose consumers and salespersons were of the same gender (Tippling S,1993). Male outreach workers may play an important role as Educators, Motivators, Counselors and Providers; and may strengthen the information, education, and communication (IEC) campaign, especially interpersonal communication strategies targeting men in trade union movement, colleges, community training centers and homes. Expansion of educational facilities to the rural population should stimulate changes in attitudes and increase acceptance of family planning programs (Farooqi MNI, 1984, 90). Therefore, successful implementation of family planning in Pakistan may be achieved by targeting men through Male Workers.

Further, being members of the same community, Male workers will be better able to know the client's perception. Male Family Planning workers can help identify realistic changes in the sexual behavior of men by listening to their feelings (Gordon G, 1992: 45). And repeated encounters by male workers will foster contraceptive use among male members of the community. It has already been shown in Pakistan that repeat visits bring in far more acceptors than just 1 visit and repeated personal contacts should be maintained with the target population (Eger G, 1976: 24).

Study analysis indicate that Outreach generates incremental contraceptive use, continues to foster contraceptive use because of high frequency of encounters,

generates a demand for contraception and weakenes sex preferences for offspring (Phillips JF; Hossain MB; Arends-Kuenning M, 1996:217).

However, increasing male involvement in family planning should not distract efforts to improve the status of woman but should enhance communication within relationships and foster shared responsibility in the reproductive health process

1.9 CONCLUSION

The above studies confirm the role played by men in their facilitating or inhibiting the adoption of family planning. Men play a key role in bringing about gender equality since they exercise preponderant power in nearly every sphere of life, ranging from personal decisions regarding the size of families to the policy and program decisions taken at all levels of government. Without a deeper understanding of how family planning importance is viewed and how it is negotiated and how it takes place , attempts to intervene and change the course will founder. Well intentioned exhortations by women to change practices, such as use of condoms, may fly in the pace of reality; simultaneous health education campaigns that target men are needed. A more equitable sharing of fertility related decisions will be possible only if men acknowledge family planning as a joint responsibility, and therefore and thus the responsibilities of fatherhood should be emphasized for men.

Therefore, it is necessary to educate males on how they can take greater responsibility in contraceptive practice and at the same time support women's participation in family planning programs. These ideas can be incorporated into existing training

courses either in family planning clinics or in official settings but the husband should be focus of the program. Even, if the greater involvement of male in family planning can not be achieved in the immediate future, improvement in knowledge and support of family planning is important in terms of overall effects on fertility, since the husband's approval is often one of the most important determinants of contraceptive use. "Men are key to the changes in attitude about family planning (Ahsan SB, 1992:19). Thus an education program through male workers targeting men is the immediate and urgent need of the present time, in order that family planning program may take off at a self sustainable point.

"So many deeds cry out to be done,
and always urgently;
The world rolls on,
Time passes.
Ten thousand years are too long,
seize the day, seize the hour!"

Chairman Mao Tse Tung