Working Paper No. 18

Women, Men and Infant Feeding in the Slums of Dhaka City: Exploring Sources of information and Influence

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MCH-FP Extension Project (Urban)
Health and Population Extension Division

ICDDR,B
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1996

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MCH-FP Extension Project (Urban)

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Foreword

I am pleased to release these reports on urban Maternal and Child Health and Family Planning issues which are based on the operations research activities of the MCH-FP Extension Project (Urban) of the Centre. Over the years, the Centre has acquired a unique expertise on urban development matters that ranges from operations research on reproductive health, child survival and environmental issues to providing technical assistance for capacity building to service delivery organizations working in urban areas.

This work has produced important findings on the health conditions and needs of city dwellers, particularly the poor and those living in slums. The research has also identified service delivery areas in which improvements need to be made to enhance effectiveness. Together, these research findings have been translated into interventions currently being applied in government and non-government settings.

In order to carry out this innovative work, the Centre has established a partnership effort known as the Urban MCH-FP Initiative, with different ministries and agencies of the Government of Bangladesh and national non-government organizations, notably Concerned Women for Family Planning, a national NGO with wide experience in the delivery of MCH-FP services. The partnership receives financial and technical support from the United States Agency for International Development (USAID).

The overall goal of the partnership is to contribute to the reduction of mortality and fertility in urban areas. In practice, this joint work has already resulted in the development and design of interventions to improve access, coordination and sustainability of quality basic health services to urban dwellers with emphasis on the needs of the poor and those living in slum areas.

The Centre looks forward to continuing this collaboration and to assist in the wider dissemination and application of sustainable service delivery strategies in collaboration with providers in government, the NGOs and the private sector.

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Summary

A series of in-depth interviews was conducted with mothers and fathers of infants living in slum communities of Dhaka city. Sources of information and influence over infant-feeding behaviour and, in particular, the role of husbands, were explored.

The study found mothers to be intimately involved with decisions and behaviours relating to infant-feeding, but also revealed that they do not act alone. Other individuals are influential, and within the urban slum context, where contacts with extended kin are fewer than in the rural setting, husbands appear to be particularly important. Husbands were found to influence decisions and behaviours relating to infant-feeding in a number of ways. A husband's influence may be direct, through the imposition of his will or, more commonly, through discussion and negotiation with his wife on matters relating to infant-feeding. Influence may also be more indirect, acting through the roles of husband and wife and their relationship to one another. A husband's free movement outside the home, his interactions with a wider group of people, including doctors, shop keepers and employers, his control over money and role as the purchaser of food for the household, are all factors that mean he can influence infant-feeding behaviour.

Findings also highlighted the fact that the sources of information available to men and women differ markedly, so that their knowledge and attitudes towards infant-feeding (as well as other issues related to child health) may diverge in important ways. Men are exposed to a wider range of sources of information, with a greater potential for inconsistency. Men are more likely to watch television and listen to the radio. In terms of health personnel, men are more likely to interact with private doctors and pharmacists, and women with NGO or government field workers and clinic staff. Given these differences, it is perhaps not surprising that men were

found to be more familiar with tinned milks than wives, and that wives were better acquainted with certain health messages commonly promoted through the primary health care system.

In addition to divergent sources of information, men and women play distinct roles with respect to child care and feeding. Despite some changes in urban Bangladesh, the predominant pattern is still one of men as breadwinners and providers, and women as carers and nurturers. This means that the perceived advantages and disadvantages of alternative ways to feed infants may differ greatly between the two, the costs and benefits involved being different. Husbands were commonly found to be the ones who purchase feeding bottles and tinned milks, and this represents a way for men to fulfil the role of a doting father. Wives more commonly mentioned the time costs and inconvenience of certain infant-feeding patterns than husbands.

It cannot be concluded from the present study that men always have a positive or negative effect on breast-feeding. Nevertheless, they clearly have an important influence, and programmes that fail to recognise this (and the influence of other actors) over-simplify the situation and will be ineffective. The current emphasis on health education via field workers targeting mothers in their homes must be diversified to enable contact with other groups, in particularly men. Innovative programme approaches must be designed to reach husbands with appropriate messages, and which recognise their current sources of influence and information. Efforts must be made to alter sources of inaccurate information, as well as to provide alternative ways in which men can become better informed regarding their child's nutrition and health. Educational campaigns should attempt to reverse the trend away from bottle-feeding among richer groups as well as the poor, and to break the association between bottle-feeding and a modern, wealthy life-style, to which many aspire. Men must be encouraged to take

more responsibility, and they must be shown routes through which they can support their wives in the care of their children, including breast-feeding.

Though it may seem obvious to many that mothers do not act alone in the maintenance of their families, the fact remains that the majority of child health programme activities in Bangladesh fail to recognise this. It is high time that the influences and constraints under which mothers act are acknowledged, and programme initiatives implemented that seek directly to involve other important individuals, particularly men.

"Whether we are talking about breast-feeding or weaning, oral rehydration therapy or immunization, regular growth or frequent hand-washing, it is obvious that the mother stands at the centre of the child survival revolution" (UNICEF 1986)

Introduction

It seems something of paradox that, in a patriarchal setting such as Bangladesh, where male authority within the household and the subordination of a wife to her husband's wishes goes without question, the vast majority of research and programme activity aimed at improving child survival is focused exclusively on women. As the quotation from UNICEF above illustrates, the responsibility for child welfare has been laid firmly at the feet of women.

We do not question here that women, and in particular mothers, play a central role in the care and upbringing of their children. Indeed, there is evidence to suggest that, in most cultures, childcare is almost totally performed by women [1]. However, we do suggest that mothers are not individual actors, and that their decisions regarding childcare, including infant-feeding, are shaped and influenced by the social context in which they operate.

Ewbank [2] notes that the use of narrow theoretical frameworks that consider women as rational and single, independent decision-makers may lead researchers to overlook important social and cultural factors that shape behaviour. Other researchers also call for research that examines the composition, structure and organisation of households, and their effects on child health, rather than designating the individual woman as the unit of analysis. In their study of malnutrition in Western Kenya, Reynolds Whyte and Kariuki [3] note that "while nutrition intervention programmes tend to treat women as individual actors, women see themselves as enmeshed in

social relationships which affect their ability to care for their children." In Guatemala, it was found that men played important roles in health care by providing money and purchasing medicine and foods, even though women were given primary responsibility for the health of the family [4].

In urban Bangladesh, as in many other settings, the current trend in infant-feeding practices is towards earlier supplementation and greater use of tinned milks and feeding bottles [5]. Although concern has been voiced over the emerging patterns of infant-feeding, there has been little effort at understanding the factors bringing about such changes. It is hypothesized here that decisions and behaviours influencing the feeding of young children are not taken in isolation by mothers, but that other individuals, including men, play important roles. To understand the reasons why women adopt particular feeding patterns for their infants, we need to recognise the familial and broader social structures within which they have to operate; the influences and constraints upon their behaviour.

The present study aimed to produce data of a more detailed qualitative nature, to complement quantitative studies which have documented the current patterns and trends in feeding practices. Such data should help to identify the factors contributing to certain infant-feeding behaviours and suggest ways in which women may be encouraged and assisted to feed their infants in more health-promoting ways. This paper[1] examines the role that husbands play in infant-feeding in the urban slum setting of Dhaka, and explores:

(1). the ways in which husbands can exert an influence over the decisions and behaviours surrounding infant-feeding, and the extent to which that influence may vary between families,

[1] Additional findings from the study that relate to women's and men's knowledge and attitudes to alternative ways of feeding infants are presented in a separate Urban MCH-FP Working Paper [7].

and,

(2) the ways in which husbands' attitudes, knowledge, and sources of information differ from those of their wives, such that their influence may lead to different behaviours than if women were the sole actors in decisions regarding infant-feeding.

Background and Setting

The Urban Health Extension Project (UHEP), the predecessor of the MCH-FP Extension Project (Urban) of the International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDRB) was a health and family planning research project working in the slum communities of five thanas[2] of Dhaka city. Between April 1991 and January 1994, the project maintained a demographic and health surveillance system, the Urban Surveillance System (USS), in a representative sample of the population of these five thanas. Data from a baseline survey carried out between August and November 1990 suggest that in these slum communities, as in many other developing country settings, traditional patterns of infant-feeding are changing. Baqui *et al.* [5] found that, although the prevalence of breast-feeding was high (more than 90% for children aged less than one year), exclusive breast-feeding was rare even in the early weeks of life. The trend appears to be towards earlier supplementation and greater use of tinned milks and feeding bottles. Baqui *et al.* [5] reported that around 40% of infants aged less than six months received milk supplements.

These new patterns of infant-feeding are emerging in a sociocultural and economic setting that differs in many respects from the rural context.

[2] A *thana* is an administrative area of the city comprising a population of approximately 300,000.

Though few studies have systematically documented the patterns of social formation in urban slums, experience suggests that family structures, networks of social support and communication, and gender roles may differ significantly from those in the village setting. It is suggested that, to understand the determinants of changes in infant-feeding, it is important to consider the behaviour in this broader context. This paper goes some way towards doing this by looking at husbands, an important group of actors normally ignored.

Methodology

In the present study, the USS was used to identify families where there was a child aged less than 12 months (Table 1 shows the approximate age of the children at the time of interview). Information gathered by the surveillance system allowed approximately equal numbers of exclusively breast-fed and not exclusively breast-fed infants to be selected,[3] and also ensured that characteristics, such as age, education, and employment status varied among the respondents.[4] The primary respondents for the study were the mothers and fathers of selected children drawn from different slums throughout the USS sampling area. In addition to this, interviewers identified other influential individuals, such as relatives, friends, employers or neighbours, who were also interviewed. Once field work was underway,

[3] An exclusively breast-fed infant was defined as one who had received nothing other than breast-milk up to 4 months of age, except pre-lacteal feeds given in the first 1-3 days of life and water. A not exclusively breast-fed infant was one who had been given foods other than breast-milk before 4 months of age. The present study aimed primarily to increase our understanding of the reasons for supplementation early in an infant's life. This led to a study design that included families of exclusively and not-exclusively breast-fed infants, as defined above. It is also recognised that delayed or inadequate supplementation of an infant's diet is an important public health problem in this setting. Although the study did not focus on this issue specifically, relevant information was gained, and is discussed where appropriate in both this paper and elsewhere [6].

[4] The percentage of Hindus living in slum areas of Dhaka is considerably smaller than for the whole population of Bangladesh. Within the USS system around 4% of the population are Hindu. This made it difficult to find suitable Hindu families to be found and unfortunately only four families were recruited into the sample.

it soon became clear why men have often been left out of the picture. Although the original intention was to interview husbands and wives as soon after one another as possible, finding time to speak to husbands was difficult, and most interviews had to be conducted early in the morning, after dark, or on Friday, the day of rest. Despite these problems, only two cases had to be dropped, and a total of 28 husband-wife pairs were successfully interviewed. Interviews were also conducted with nine other influential people, making a total of 65 respondents in all. In many cases the respondents were interviewed more than once, so that inconsistencies and gaps in understanding could be clarified. Interviews were conducted between February and June 1993. Tables 2, 3 and 4 show basic information on the respondents interviewed, and the appendix gives a list of the case study households.

Table 1. Age distribution of the sampled children by reported breastfeeding status

Reported age in completed months* (at the time of interview)	Number of Children	
	Exclusively breastfed	Not exclusively breastfed
2-3	2	1
4-5	3	3
6-7	7	9
8-9	2	0
10-11	0	0
12	1	0
Total	15	13

* Since mothers and fathers could not always be interviewed soon after one another the age of the children at the time of interview differed slightly in some cases.

Table 2. Age distribution of respondents (parents) by reported breastfeeding status of the children

Age of respondents (years)	Fathers		Mothers	
	Exclusively breastfed	Not exclusively breastfed	Exclusively breastfed	Not exclusively breastfed
<20	0	0	2	1
20-29	6	5	9	8
30-39	6	5	3	4
40-49	1	2	1	0
50+	2	1	0	0
Total	15	13	15	13

Note: For one case where there was a large inconsistency between the mother's and the father's report of child feeding status the mother's report has been used for categorising the case.

Table 3. Educational level of respondents (parents) by reported breastfeeding status of the children

Education of respondents	Distribution of respondents			
	Fathers		Mothers	
	Exclusively breastfed	Not exclusively breastfed	Exclusively breastfed	Not exclusively breastfed
None	9	7	12	11
Class 1-5	5	3	2	2
Class 6-10	1	3	1	0
Total	15	13	15	13

Note: For one case where there was a large inconsistency between the mother's and the father's report of child feeding status the mother's report has been used for categorising the case.

Table 4. Occupational status of the respondents (parents) by reported breastfeeding status of the children

Occupational status of the respondents	Distribution of respondents			
	Fathers		Mothers	
	Exclusively breastfed	Not exclusively breastfed	Exclusively breastfed	Not exclusively breastfed
Own household work	0	0	12	9
Government unskilled worker	3	1	0	1
Government semi-skilled worker	1	0	0	0
Petty trader	2	0	0	0
Rickshaw/van puller	3	3	0	0
Semi-skilled crafts/ factory employee	3	6	0	1
Semi-skilled crafts self-employed	2	1	1	1
Day labourer	1	1	0	0
Baby taxi driver	0	1	0	0
Domestic maid	0	0	2	1
Total	15	13	15	13

Note: For one case where there was a large inconsistency between the mother's and the father's report of child feeding status the mother's report has been used for categorising the case.

Information was collected through open-ended, semi-structured interviews by teams of two - one interviewer and one note-taker. A detailed interview guideline was prepared by the team of investigators prior to starting the interviews, though this served only as a guide, and was revised and expanded as the work progressed and new areas of interest emerged. Through the interviews, the team collected information on the feeding history of the youngest and previous children, attitudes and opinions towards alternative foods for infants, sources of information and advice, problems and concerns surrounding infant health and feeding, and involvement of different individuals in decisions and behaviours relating to infant health and feeding. Interviews were tape-recorded and later transcribed. Analysis was performed using both the cutting and pasting facilities in Wordperfect and also the textual analysis package, The ETHNOGRAPH. In the initial stages of analysis all three authors worked independently to identify local terminology, distinguish common themes and organise the data into meaningful categories. Discussion sessions followed where the data collected were evaluated in the light of experience and observation from routine work in the slums of Dhaka,[5] to reach a common interpretation of the available information. The first author then took responsibility for organising the team's findings into two papers; the present paper, and another Urban FP/MCH working paper which deals with the knowledge and views of respondents towards alternative ways to feed infants [6].

Findings

1. Husbands and Infant-feeding: Degree of Involvement and Mechanisms of Influence

The present study revealed, not surprisingly, that the degree of direct involvement of husbands in decisions and behaviours relating to infant-feeding

[5] All the investigators have several years of research experience in the slum setting.

varies considerably from household to household. However, on the whole, husbands were found to be well informed about the way their children were being fed, and to be interested in child feeding and child health as topics of conversation. Interviews with husbands produced lively discussions, and respondents freely expressed opinions about alternative ways to feed children. The information gathered from the present study provides illustrations of the different ways in which husbands may influence infant-feeding patterns, whether intentionally or not. The case studies show that, even in situations where a husband's direct involvement is limited, his behaviour and his interactions with his wife may nevertheless have a very important influence. This is true because women in this setting have neither the material nor social resources to act independently in the maintenance of the welfare of their families.

Some of the ways in which husbands were found to influence infant-feeding are discussed below with examples.

1.1 Direct imposition of the husband's own wishes

Findings from this study suggest that it is relatively rare for a husband to directly impose his will with respect to infant-feeding without any consultation with his wife. Nevertheless, dependence on her husband for social and material support may force a wife to feed her children according to his wishes, even if she would herself choose to feed differently, and examples of this happening were found. One mother asked rhetorically when questioned about her husband's influence over child care:

> *"If you listen to the neighbourhood people are they going to feed you?"* (case no. 12, exclusive mother)

> *Nikhil*[6] *is in his early thirties and works as a government cleaner from early morning to noon. He takes a keen interest in the health of the*

[6] All names have been changed.

children and spends most afternoons at home. His parents live close by in the same housing colony and he and his mother exert a strong influence over the feeding of the children. He and his wife used to live as a joint family unit with his parents until recently. His wife's parents have been dead for many years and she feels that she has nobody else to turn to for advice or support in these matters. In the case of her oldest child, her mother-in-law told her to feed tinned milk despite the fact that her breast-milk was coming well. She would not have chosen to do this in the absence of her mother-in-law's instructions. It was Nikhil who decided that the youngest child should be fed tinned milk alongside the breast-milk and he who bought the milk and told his wife to feed it. His wife expressed misgivings about feeding this milk: "if you feed tinned milk the child will not be all that strong (shokti)", but felt she had little choice in the matter: "what my husband says to feed that is what I feed."
(case no. 21, not exclusive)

1.2 Discussion and negotiation with the wife (and other family members)

Rather than this extreme form of husband's influence, it is more common for discussion and negotiation between husband, wife and other individuals to take place. The wife's relationship to the child and her role as the primary care-giver gives her access to important information and experience, which is usually recognised by her husband. In our current sample, it was common for both men and women to refer to discussion with their spouse regarding decisions about child feeding. Discussion may take a variety of forms and result in the husband influencing behaviour in a number of different ways. Examples of discussion between husband and wife leading to each of the following were found:

1.2.1 Support for the wife's existing opinions or wishes

It was of interest to explore the events surrounding the decision to introduce supplements in the households where the youngest child was fed not exclusively (13). In the majority of cases (9), it was the wife who initially drew attention to the need to provide the child with other foods, but she was invariably supported in her opinion by her husband. Husbands commonly mentioned that their wives told them that the child was not getting enough milk, that its stomach was not being filled, and that they too noticed the child was crying a lot.

Respondent: *"When she feels hungry that is when I buy it and feed it."*
Interviewer: *"How do you know she is hungry?"*
Respondent: *"She cries, and her mother knows that milk is not coming."*
Interviewer: *"Does she get any breast-milk?"*
Respondent: *"Yes she gets breast-milk, but you know, if her mother can not eat properly then she won't get the breast-milk, if she can eat properly then the child will not need this food, she will get breast-milk."*
(case no. 16, not exclusive father)

Wives reported that their husbands found the child's crying irritating and that they, therefore, supported their own suggestion that the child needed additional food.

Examples were also found where husbands apparently supported their wives in their breast-feeding efforts.

Tahmina and Alam had experimented using tinned milk in the past with their older children but both felt that breast-milk is the best food for their young child. Tahmina reported that her husband always tells her

to breast-feed and to eat properly and that he tries to bring good food to make her breast-milk come more.
(case no. 4, exclusive)

Thus, it seems that in many cases the wife, due to her intimate association with the child, is the first to raise issues related to infant-feeding. However, her husband may often reinforce her perceptions and sanction certain behaviours that result from these.

1.2.2 Introduction of new ideas or information not previously considered by the wife

Since the social networks and communication channels of men and women are very different in the slum communities of Bangladesh, husbands may often be the source of new ideas and information that act to influence infant-feeding patterns. Husbands are often the ones who introduce new 'technologies' to the household, such as new brands of tinned milk, a feeding bottle, or perhaps another type of infant food. This is discussed further below.

Tahmina recalled the time when her older son was born and her husband brought tinned milk to feed to him:

"I started to give the dibber to my elder son at 40 days of age, after we had had his photograph taken. Sometimes he would take it and sometimes not and he would vomit. He did not want to take the feeder in his mouth so I stopped giving it. His father brought this for fun because all the other people do this, I didn't ask him to bring this."
(case no. 4, not exclusive)

Nazma identified that the child needed to be fed something other than breast-milk because the milk was not filling the child's stomach. She

asked her husband to bring cow's milk as she thought that this would be the next best food to mother's breast-milk. However, rather than following his wife's wishes Jalal provided tinned milk, Dano, instead. He regards his wife as rather old-fashioned and rural in her way of thinking and decided that Dano was a more appropriate food for his daughter to be fed.
(case no. 20, not exclusive mother)

1.2.3 Opposition to the wife's opinions or wishes leading to conflict

Having mentioned above that congruence was found between many husbands and wives in their attitudes and decisions regarding infant-feeding, conflict was also evident in some cases.

Milon thinks that his young child should be fed tinned milk, and tells his wife to give Dano and also Horlicks to the child as he has seen other people doing in the area. Meanwhile, his wife, Asha, complains that he tells her to do this, and does not agree that this is the best food for the chid. She is at present ignoring his wishes and prefers to feed the child khichuri[7] instead.
(case no. 9, exclusive)

Mafiz and Marufa live as a couple with their children and no other relatives. Though both of them mention that they tend to discuss and decide things together, Mafiz does try to impose his will in some matters. They both feel that breast-milk is the best food for the child and would like to avoid feeding other things. However, Mafiz refuses to let Marufa use any other form of contraception except the pill, and this is causing her breast-milk to get less. Marufa feels she has to use

[7] A dish where rice, lentils and sometimes vegetables are all cooked together; prepared in a soft, mushy form when given to small children.

supplements in the child's diet and this is now a source of conflict between the two.
(case no. 23, not exclusive)

1.3 Husband's facilitating or inhibiting action

As well as participating directly in discussion about infant-feeding with his wife and other individuals, the power a husband holds within the household, and the distinct roles of men and women, mean that other aspects of a husband's behaviour may affect infant-feeding patterns, either directly or indirectly.

Support for the wife's decision to introduce things besides breast-milk to the child's diet may often take the form of buying the supplemental food. Among the not exclusive families, in all except two cases, it was the husband who provided the foods that were fed, usually a tinned milk of some sort. Husbands are the ones who go to the shop to buy these foods, and they very often also make the decision about which particular brand should be purchased.

In addition, since husbands are the primary, if not the sole wage earners, and are also responsible for food shopping[8] in most households, they have an important influence over the mother's diet. All wives mentioned their own food as an important factor in their being able to provide breast-milk to their child.

"If I could eat more milk, fish and rice, say three or four times a day I am sure I could produce more milk, the tinned milk is expensive, but I cannot eat more because I have so many mouths to feed."
(case no. 24, not exclusive mother)

[8] Hilary Standing [7] also notes that shopping for food and household provisions remains a strongly male task in West Bengal.

Hazera complained strongly about her husband during the interview saying that he is lazy and does not provide enough food for her to eat. She says that she cannot eat all the vegetables and things that she should and that this is why her breast-milk is not sufficient to satisfy her child's needs. Sometimes she herself tries to buy extra things from the bazaar, but still her milk is not enough. She says that her husband tells her not to feed the child tinned milk, because of the expense, but she ignores him and wants to put the child's health first.

"Their father does not want to live well, if we buy and feed the children milk then I will do that myself."
(case no. 26, not exclusive mother)

As well as leaving the wife vulnerable to inadequate nutrition, poor relations between husband and wife can affect the child's feeding in other ways.

Asma's children have experienced a variety of feeding patterns largely because of the circumstances of her marriage to Shafique. When her eldest son was six months old, her husband married again. Asma became angry and went to her parents' house leaving her child with her husband. Her husband bought tinned milk and the child's step mother fed this to the child. When Asma was in her parents' house she realised that she was already pregnant for the second time, and she subsequently gave birth a daughter. Being faced with bringing this child up without a husband she gave her away to some other people. She did not breast-feed that child at all. She came back to her husband's house after one and half years with her parents. She then gave birth to her third child, a daughter, who was given breast-milk until she was four years old.
(case no. 28, not exclusive)

Abdullah is in his late twenties and pulls a rickshaw from noon until late at night. His marriage to Mariam was arranged by the local landlord since her father is dead and she had been living in Dhaka city away from her rural relatives for many years. Relations between Abdullah and Miriam are not close. He does not always stay with her, coming and going as he pleases. Abdullah has little direct involvement with the care of his two children. Miriam's mother lives with her and is an important source of advice regarding child care and feeding. Abdullah provides very little money for the family expenses and Miriam finds it difficult to feed her children vegetables and other foods alongside the breast-milk. She gave only breast-milk for one and a half years to the older son, and he has already been admitted to a nutrition centre a number of times. Her youngest son was six months old at the time of interview and already poorly nourished.
(case no. 5, exclusive)

Tahmina is now enjoying relatively good relations with her husband and he takes a keen interest in the children's health. However, she told us about her experience at the time of the birth of her eldest son. At that time she started to feed her child with tinned milk and the feeder from just 40 days of age

Respondent: *"If I did not have milk then what could I feed?"*
Interviewer: *"You were starving when your child was only 40 days old, why was that?"*
Respondent: *"At that time my husband was having an affair with a neighbour and we argued about this, he used to give me food for two or three days and then nothing for two or three days, the child was not getting enough milk."*

Though her relation with her husband was not good at that time, and he refused to provide for her, Alam did agree to provide tinned milk for his son, and so Tahmina resorted to feeding this.
(case no. 4, exclusive mother)

Whether her lack of milk was actually caused by inadequate nutrition or rather by mental upset due to the poor relations with her husband, or indeed whether the plea of insufficient milk was a tactic employed by Tahmina to gain additional support for her child, is impossible to say. Nevertheless, the example clearly shows how relations between adults may impact upon the well-being of children.

By identifying the above ways in which husbands may exert an influence over infant-feeding behaviour, we do not suggest that they are either exhaustive or mutually exclusive. Any particular behaviour is likely to be the outcome of a complex of interactions, including not only wife and husband, but also other individuals. Nonetheless, the above examples illustrate that husbands are important actors with respect to infant-feeding, even though they are usually overlooked by both research and programme activity.

2. Family Structure and the Influence of Other Individuals

Just as it is artificial to consider only women when we try to understand the determinants of infant-feeding patterns, or other health-related behaviours, it is also unsatisfactory to examine husbands' and wives' roles without also considering the wider network of relations with kin and non-kin. The degree and type of involvement of any individual husband will vary according to the circumstances of his family and broader social setting. The present study attempted to gather information on sources of information and influence with respect to infant-feeding behaviour, both within and outside the family.

Though intuitively one might expect the urban slums to be home to a much wider array of living arrangements than rural areas, in fact there has been relatively little documentation of the living patterns in this setting. In rural Bangladesh, a mother with her young child is usually surrounded by her husband's kin, living in her father-in-law's bari.[9] Islam and Zeitlyn [8] reported a pattern of matrilocal settlement in their anthropological study of Dhaka bustees, but to what extent this is peculiar to the area they studied or a general phenomenon has not been clarified.

The 28 families that were included in the present study could be divided into three broad categories of household structure as follows:

nuclear (17)
(husband, wife and children, no senior relatives from either side sleep or eat in same household)

patrilocal joint (8)
(husband, wife and children, plus senior relatives from the husband's side sleep and eat in same household)

matrilocal joint (3)
(husband, wife and children, plus senior relatives from the wife's side sleep and eat in same household)

This categorization shows that most families included in the study were nuclear units without any older relatives. However, interviews revealed that in some cases relatives live nearby, visit regularly, and exert an important influence on familial decisions. Table 5 and 6 illustrate the degree of influence of the husband's mother and the wife's mother with regard to infant-feeding in the 28 families studied. Table 5 shows that in 13

[9] The rural homestead constructed on raised ground, usually consisting of a group of houses built around an open courtyard.

of the study families the husband's mother was identified as having some influence, whereas the same was true for the wife's mother in only nine families (Table 6). In addition to the husband's and wife's mother, a number of other relatives were identified as significant sources of information and influence. These individuals are listed in Table 7. The present sample suggests that, where individuals other than the couple exert an influence over child care and feeding, it is the husband's relatives who are most likely to be the players. In four families, relatives from both sides were mentioned as having some degree of influence over these decisions. Not surprisingly, the influence of particular family members appeared to depend on the nearness of residence and the frequency of contacts between individuals and the parents of the child.

Table 5. Location and influence of husband's mother

	Number of families
Lives in same household, has large influence	5
Lives in same household, some influence	2
Lives elsewhere, frequent contact†, large influence	3
Lives elsewhere, intermittent contact†, some influence	3
Lives elsewhere, infrequent contact†, little influence	5
No contact/no influence mentioned	10
Total	28

† Frequent contact is taken to be at least once in two weeks, but in most cases these individuals live close by and visit every few days, if not daily. Intermittent contact is taken to be less than once in two weeks, but more frequently than twice or three times a year. Infrequent contact is taken to mean only twice or three times a year.

Table 6. Location and influence of wife's mother

	Number of families
Lives in same household, has large influence	3
Lives in same household, some influence	0
Lives elsewhere, frequent contact†, large influence	3
Lives elsewhere, intermittent contact†, some influence	3
Lives elsewhere, infrequent contact†, little influence	0
No contact/no influence mentioned	19
Total	28

† Frequent contact is taken to be at least once in two weeks, but in most cases these individuals live close by and visit every few days, if not daily. Intermittent contact is taken to be less than once in two weeks, but more frequently than twice or three times a year. Infrequent contact is taken to mean only twice or three times a year.

Table 7. Other relatives mentioned as sources of influence or information regarding infant-feeding

Relatives	Husband mentioned	Wife mentioned
Husband's aunt (Fufu)	2	1
Husband's father	3	3
Husband's older brother	4	0
Husband's older brother's wife	2	0
Wife's sister	0	1
Wife's brother	0	1
Wife's cousin (Khala-to bon)	0	1

Findings suggest that the family structure and the degree of involvement of senior relatives in decisions regarding childcare affect both the relationship between husband and wife, and the role that the husband plays in this sphere of activity. Though variation was found, among couples living with or nearby the husband's family, it was common to find the husband's mother to be influential, and that she, either alone, or together with the husband, exerted influence over the wife's feeding patterns. Husbands living with their own mothers often seemed to be deferential to them, recognising their superior knowledge and experience. Wives reported feeding their children in ways that they would not choose were they living independently of their mother- or parents-in-law. In this situation, discussion between husband and wife on matters relating to child feeding appeared to be less common and the mother's power to take independent action may be severely limited. A similar pattern has been described for rural Bangladesh in a number of studies [9,10] as well as elsewhere [11,12].

Afzal and Sajeda live in a joint family including Afzal's mother. It was not difficult to see the important influence of Sajeda's mother-in-law as she answered our questions and constantly interrupted the interview. Though relations with her mother-in-law are not bad and she gets help with childcare, Sajeda says that if she lived separately, she would be able to make many more decisions herself regarding her children's feeding and welfare.
(case no. 6, exclusive)

Among the couples living as nuclear units and without influential relatives living nearby, it was more common for both husband and wife to mention discussion with their spouse regarding child feeding. In this situation, the wife's opinions and initiatives are more likely to be put into practice. In the nuclear setting, the husband and wife can and have to communicate more directly. The husband may be forced to get involved in

spheres of life that were perhaps more traditionally dominated by women, for example calling the dai[10] at the time of a delivery, providing for his wife in the postpartum period, and deciding how to feed the children. Thus, in the urban slum setting, husbands may play a more important role in childcare decisions than in the rural context. However, not all men respond to this situation, and a woman remains dependent upon her husband's support and cooperation. The absence of the extended family may offer the potential for autonomy, but may also leave the wife in a very vulnerable position. Though the urban setting may offer women more opportunities for independent action than rural areas, both in terms of knowledge acquisition and income generation, women nevertheless remain constricted in their movements and behaviour, particularly if they have young children.

The present sample does not permit generalization about the role of husband, wife and other family members among families that exhibit the matrilocal joint structure. Norris Stark [9] found that in her rural sample, this living pattern was more common among well-off families, or in cases where land or employment in the wife's family home attracted her husband to stay there. This appeared to be the case in one family in our sample, where the extended matrilocal family also functioned as a production unit making shoes. However, another of the families was a sharp contrast to this.

> *As mentioned above, Mariam's husband is unreliable and spends much of his time away from their home. Mariam's mother is old and widowed, and their decision to live together appears as an adaptive response to their shared vulnerability. While Mariam performs household tasks, collects water and prepares food, her mother can relieve some of the burden of child care.*
> (case no. 5, exclusive)

[10] Traditional birth attendant.

The age and stage of the life-cycle of husband and wife may also interact with household structure to affect the role and involvement of husband, wife and other individuals in child care. Among younger couples, there may be less communication between husband and wife, and in the joint family setting responsibility for decision-making regarding child care is more likely to be taken over by other family members.

Arif was married to Shahana when they were both very young. He still behaves very much as he used to, going out and about with his friends, who do not even know that he is married with an infant son. He is immature and leaves the care of the child up to his parents and other relatives.

Respondent: *"What is the need for me to know? There is my brother, my father, my elder sister, who am I?"*
Interviewer: *"Don't you make any decisions?"*
Respondent: *"No I don't take any decisions."*
Interviewer: *"What about in the case of illness?"*
Respondent: *"My mother and father are here, they decide."*
Interviewer: *"So, as far as your child's health is concerned whose opinion is most important?"*
Respondent: *"My father's, I follow what my father says. Sometimes my father-in-law tells me to do something, and if it seems sensible then we may follow his advice. But otherwise my father's decision is final."*
(case no. 14, exclusive father)

Tusher lives with her husband and his family. She recalled the time of her first child's birth when she was very young and shy. She said that as a new wife she could not speak to her husband and could not ask him

for foods to increase her milk such as shing mach.[11] *She was thin and weak. Her breast-milk did not come enough, and she had to resort to feeding other things.*
(case no. 15, exclusive)

In contrast, older couples living in a nuclear unit are more likely to engage in discussion, and husbands and wives often take decisions together, as reported above for Tahmina and Alam. Norris Stark [9] has noted a similar pattern among rural couples with older women being able to talk much more directly to their husbands and to express their needs.

Having illustrated that relatives may often be important actors, it should be pointed out that in a large number of cases couples were found to be living separately with their children, and reported no important influence from senior relatives of either side (12). In this context, interactions with neighbours, colleagues and other non-related individuals appear to be important sources of influence and information. Husbands' interactions outside the home may be particularly important sources of new information, as discussed further below. Neighbours were mentioned by both husbands and wives as a source of information. As is common in many settings, respondents knew how other young children were being fed, and often made comparisons between their health and that of their own child. It appears common for neighbours to exchange information on issues related to child feeding, particularly regarding the suitability and characteristics of different types of foods. Since tinned milks are a relatively new phenomenon, there is less consistency in opinion about the qualities of these products than more traditional infant foods. Sharing of information between neighbours appears to result in a clustering of behaviour, so that in certain areas one particular type of tinned milk is regarded as the best and is employed by most people,

[11] A type of fish.

whereas in other areas another brand may be popular.[12] Couples who were living in nuclear units tended to mention neighbours as sources of information more often than those who were living in joint households.

> *Nazma explained that her parents live in the village and she visits them only rarely, and that her mother-in-law visits from time to time but offers no advice on infant-feeding. In the absence of relatives, the neighbouring people (para manush) were an important source of information and support in her decision to feed supplementary foods to her child who was suffering from inadequate milk supply.*
> (case no. 20, not exclusive mother)

3. Husbands and Wives: Sources of Information and Influence

Having described some of the ways in which husbands may act to influence infant-feeding behaviour, and the way this influence may vary between families, this section goes on to explore the differences between husbands and wives in their own sources of information and influence. These are important because they mean that husbands and wives may have different attitudes, knowledge, and preferences with regard to infant-feeding.

3.1 Familial roles of husband and wife

The roles of husband and wife in relation to the upbringing and care of their children remain very clearly differentiated among the slum dwellers of urban Bangladesh. Despite an increase in female employment, women remain essentially the nurturers of children, and men the bread-winners for the family. Women retain a much closer bond to their children, spending longer periods of time with them than their husbands and caring for their immediate needs. Men, on the other hand, work outside the home and bring home food and other requirements for the family.

[12] For a fuller discussion of the qualities of different types of infant food see Salway, Nahar and Ishaque [6].

In the present sample, the majority of husbands interviewed worked long hours, typically from 7 am to 6 or 7 pm, and thus spent limited time at home. Those who had government jobs tended to work shorter hours, and rickshaw pullers often chose to work one shift, either morning or afternoon, meaning that they had the remainder of the day to rest at home. In most cases, however, husbands spent much of the day outside the home and had little direct involvement in feeding or caring for their children. Husbands did mention spending time with their children, but it tended to be leisure time; taking them out to visit neighbours or to have a treat of some kind, rather than routine care, such as washing or feeding. Having said this, many husbands did know how to prepare bottles of milk or other supplements for their child. However, it seems that they only feed the children under special circumstances, such as when the wife is ill or absent for some reason. The fact that husbands and wives have such clearly defined roles with respect to child care, including feeding, has important implications for how they each perceive the advantages and disadvantages of alternative modes of feeding.

Since husbands and wives perform different roles with respect to infant-feeding, they are likely to make different assessments as to the convenience of any particular form of feeding. It was not surprising to find that among our sample, wives were more likely than husbands to talk about the pros and cons of preparing and feeding different foods, the time involved, and the implications this has for their other activities. Almost all mothers mentioned the convenience (shubidha) or bother (jhamela) associated with methods of feeding, though interestingly there was little consistency in opinions. Among both exclusive and not exclusive breast-feeding women, about half mentioned the convenience of using feeding bottles, while a quarter in each group specifically stated that breast-feeding is more convenient. A few fathers did express opinions about the convenience of different options for feeding and discussed this in relation to

the other activities to be performed by their wives. However, they too showed little agreement in their opinions. As mentioned above, husbands are involved in the provision of breast-milk supplements, and this has implications for their time. Several husbands stated a preference for tinned milk rather than fresh animal milk, since it can be bought less often and easily stored for long periods.

A husband has limited ways in which he can be directly involved in the care of his children. Nevertheless, he may be keen to fulfil the role of the doting father. In interviews, husbands frequently used the first person, "I or we" not "she or they" when talking about infant-feeding, suggesting that they do consider themselves part of these decisions, even if they are not directly involved with the feeding of their children.

One way in which a husband may show his commitment to his child is by providing a feeding bottle and tinned milk, both signs of wealth and modernity. As noted above, men are almost always the ones who buy these items, sometimes in the absence of requests by the wife, and they may also be given as presents to relatives and friends following the birth of a child.

> *Sajeda is Alam's second wife and she has one son. Alam is often drunk and generally takes little interest in either his wife or his child. However, from time to time he brings things for the child. Sajeda complains that they are usually inappropriate for the child, things that the child is too young to eat, like sweets. Alam is also the one who bought the feeding bottle.*
> (case no.24, not exclusive)

Thus, a desire to make a contribution to the care of his child may encourage a husband to view tinned milks and feeding bottles in a favourable light. O'Gara and Kendell [13] noted a similar pattern in urban Honduras.

Husbands are also often the ones to provide honey or other substances for pre-lacteal feeds following delivery.

Interviewer: *"Why was honey given?"*
Respondent: *"This is to fill the child's stomach."*
Interviewer: *"How much honey did you feed?"*
Respondent: *"I went to buy the honey, and we fed one small bottle."*
Interviewer: *"Did someone tell you to buy it or did you know?"*
Respondent: *"I knew it should be given to the child after birth. I knew to give something sweet, I knew that the child needed something to fill its stomach."*
(case no. 16, not exclusive father)

Unlike her husband, a wife is inextricably linked with the care of her child, and is indeed often blamed for a child's illness or failure to thrive. Traditional wisdom in Bangladesh means that there are many concerns about breast-milk quantity and quality and that breast-feeding is problematic [14]. Findings from this study that relate to this issue are discussed in more detail elsewhere [6]. Such a prevailing attitude may lead women to have favourable attitudes towards feeding foods other than breast-milk to their children since this may mean they are less of a target for blame. The feeding of other things is invariably a joint venture, involving the husband and perhaps other individuals as well, so that the mother is no longer alone in her feeding of the child. To what extent this is an important influence on behaviour deserves further investigation.

3.2 Social networks and sources of information

In the urban slum context of Bangladesh, men are much freer to move about and to engage in conversation with strangers than are their wives. In addition, they commonly go out to work, giving an opportunity

to mix with a larger number of people. All of this means that husbands are likely to have the opportunity to acquire more varied knowledge and information than their wives. On the other hand, the fact that women are the target for many health interventions means that they have the opportunity to receive information and services that their husbands miss out on.

3.2.1 Television and radio

Although few of the respondent households owned their own television or radio, many of the husbands reported watching and listening. Men can move about freely and may go to their landlord's house, the local social club or a neighbour's place to relax and watch the television. Of the fathers interviewed, all except four mentioned watching the television or listening to the radio. Mothers less commonly mentioned the television or radio as a source of information.

Though it is difficult to draw conclusions about the extent to which information obtained from television or radio actually influences behaviour, the mass media appeared to be an important source of information for men. Sixteen fathers specifically mentioned seeing advertisements for powdered, tinned milks on the television or radio. Also, 16 fathers mentioned that they had heard messages related to child nutrition on the television or radio. The most commonly mentioned information that had been obtained from these sources was the need to feed vegetables, and khichuri to children to ensure they remain healthy. In contrast, only nine mothers talked about seeing advertisements for tinned milk, and eight that they had heard messages regarding child nutrition.

Interviewer: *"Have you got a television or radio?"*
Respondent: *"I have a radio but no television, there is a television in the next house."*

Interviewer: *"Do they say anything about child health on the radio or television?"*
Respondent: *"Yes, they say that if good food is given then the child's body will stay healthy, and they say to feed vegetables, if these are fed then the child will not get blindness, and they say lots of other things, I can't remember now."*
Interviewer: *"Do they say anything about tinned milk?"*
Respondent: *"They advertise Dano, they say that Dano is good and that the body will stay healthy."*
Interviewer: *"Do they say in what way it is good?"*
Respondent: *"It is good to eat, sweet and full of strength (shoktiman)."*
(case no. 2, exclusive father)

3.2.2 Health personnel

It has been suggested by several authors that the influence of health personnel on infant-feeding patterns may be strong [15]. Different types of health personnel may have very different effects, both because of the messages they transmit and because of the way they are perceived by the recipients of such messages.

The contrasting movements and networks of interaction of men and women of the bustee are clearly illustrated when we consider the health personnel that they have contact with and the information they gain from these individuals.

Door-to-door field workers

In the slums of Dhaka city outreach workers from government and non-government health and family planning programmes move door-to-door providing education and services. Their presence is so common that any

well-dressed stranger who happens to enter the slum is automatically assumed to be promoting contraception, or perhaps immunization. Though both men and women are familiar with these workers, it is women who have more contact with them. The workers visit the slum households during the working day, and being female themselves, take mothers as their primary 'target group'.

Among our sample around half the mothers (12/28) specifically identified field workers as important sources of information regarding infant-feeding. Messages about giving supplementary foods, in particular suji[13] and khichuri, and also the benefits of feeding colostrum, were the most commonly mentioned information to be gained from these workers.

NGO clinic staff

Non-government health programmes in urban Bangladesh focus almost exclusively on family planning and basic maternal and child health care. Staffed mainly by women, the NGO centres are clearly female space and it is rare to find men attending clinics for services or advice. The messages promoted in these centres reinforce what wives hear in their homes.

Private doctors

In contrast to the sphere of NGO health service provision, the world of private health care in urban Dhaka remains dominated by men. The majority of practitioners, whether allopathic, homeopathic, or folk (kobiraj, fakir) are men, and it appears that men are far more likely than women to visit these individuals. Husbands in our sample commonly mentioned visiting "dactars" for advice and treatment of their children, which they may or may

[13] A type of semolina.

not actually take with them for a consultation. Wives also commonly mentioned that their husbands were the ones to seek advice from "dactars." Fourteen fathers mentioned that they consulted with a doctor regarding the feeding of their children, and of these, nine fathers described how they had sought advice regarding the feeding of tinned milks to their young children.

Interviewer: *"Now you are going to feed this full cream Lactogen to the child, will you discuss this with any relatives?"*
Respondent: *"No, I will take advice from the doctor, the doctor said to buy this (half-cream) and I brought it."*
Interviewer: *"Did the doctor say to feed this up to six months?"*
Respondent: *"Yes, the doctor said that after six months full-cream should be fed."*
Interviewer: *"Did you take the child to the doctor?"*
Respondent: *"No, the doctor was known to me before the child was born, I still have not taken the child there."*
(case no. 23, not exclusive father)

In the case of hospital deliveries, the mother is often isolated from her child and from the decisions being made about its feeding. In this situation her husband may often be the one who receives instruction from the doctor and brings the prescribed tinned milk or formula.

Interviewer: *"Who said to feed Dexolac?"*
Respondent: *"The doctor advised that alongside mother's milk this milk is also needed."*
Interviewer: *"Did you ask why it is needed? Was your wife not producing breast-milk?"*
Respondent: *"Yes, she did get breast-milk, breast-milk was being produced but the doctor said that this milk is also needed."*
(case no. 25, not exclusive father, child delivered by caesarian section)

Private pharmacists and shop keepers

In addition to private doctors of various sorts, pharmacies and shops may be important sources of information and advice. A trip to the pharmacist incurs no consultation fee, and invariably numerous brands of tinned milk and infant formula are proudly displayed. Several of our husbands reported obtaining information about child feeding, and in particular tinned milk powders, from people serving in pharmacies and shops. Again, by virtue of the fact that men are free to move about and engage in conversation with strangers, they are able to acquire more varied knowledge than their wives.

3.3 Knowledge and views of husbands and wives towards alternative foods for infants

The distinct roles of men and women, both in terms of their relationship to child care, and their social interactions and sources of information, might reasonably be expected to result in different knowledge, opinions, and preferences regarding infant-feeding. The present study explored the knowledge and attitudes of husbands and wives in some depth, and revealed areas of shared common knowledge, as well as some important differences.

As discussed elsewhere [6], the prevailing attitude among both men and women in these slum communities is that breast-milk is the best food for young children. Thus, in most cases, a wife's desire to exclusively breast-feed her infant appears to be supported by her husband. However, the understanding that breast-milk is often produced in insufficient quantity, and that there is very little that can be done about this, is also universal, and shared equally by husbands and wives. Therefore, in almost all cases, a wife's suggestion that the child needs supplementary food, is met with

support from the husband. In addition to a common understanding relating to breast-milk, opinions regarding traditional infant supplements such as cow's milk and ground rice, were very similar among husbands and wives. Thus, there appears to be a traditional wisdom relating to these issues that remains common to men and women. However, a number of areas of newer knowledge could be identified that differentiated between men and women.

Respondents expressed a wide variety of opinions regarding newer infant foods, such as tinned milks and formula. Attitudes to these products were often ambivalent, though they were commonly associated with wealth and modernity. Husbands were, on the whole, more familiar with different types of tinned milks and infant formulas, than wives. This may result from several factors, including greater interaction with doctors, more frequent visits to shops and pharmacies, more watching of the television, and in general greater contact with other individuals. Husbands were often the ones to choose the particular brand of milk to feed to their children.

One area where it appeared that wives had acquired new knowledge more quickly than their husbands, was with respect to the feeding of the first milk, colostrum. Though it appears that in some communities in Bangladesh colostrum, or commonly shal doodh, has always been seen as beneficial and its feeding prescribed, in other communities it has traditionally been discarded, at least for a day or two after the delivery. Findings suggested that men may retain more traditional, negative attitudes to colostrum than their wives. Among the wives, 15 expressed strongly positive attitudes towards the feeding of colostrum, compared to just seven among the husbands. This may reflect the fact that some wives had received new information from their interactions with health workers which has changed their perception of this milk, or at least their perception of the right answer to give when questioned about this.

In our interview with Alam he expressed the opinion that the first milk, the kacha doodh, is thick and yellow and is like poison and should not be fed to the child. In sharp contrast, his wife reported that she had learnt from the radio and also from health workers who took a class in her area that this first milk is good for the child, that it contains vitamins and protects the child from illness. She says that it should be fed and that she put the child to the breast to suck just a short time after the birth.
(case no. 4, exclusive)

Another area where wives may have gained knowledge from interactions with field workers that their husbands have missed out on is in relation to the dangers of transmitting disease via feeding bottles. A small number of women specifically mentioned that dirty feeding bottles can cause diarrhoea, something that none of the men talked about.

In addition to gaining different types of knowledge, the source of men's and women's information may affect the degree to which it is valued, and, therefore, how it ultimately affects behaviour within the household. In the context of urban Bangladesh, as in many other settings, medical knowledge possessed by doctors carries great weight. Wives frequently reported that their husbands would consult 'dactars' in the case of a child's illness and that appropriate medicines would be brought home. Several men referred to their wives and older female relatives as old-fashioned or rural in their outlook, suggesting that they placed greater value on other sources of information. However, a woman's association with the modern health sector may increase her influence within the family. In one case, attendance at a formal health course run by a local organisation, and in another, attachment as a volunteer to a health NGO, had accorded particular women great respect in matters relating to child health.

Implications for Programmes

Although the present study found mothers to be intimately involved with decisions and behaviours relating to infant-feeding, it also revealed that they do not act alone. Other individuals are influential, and within the urban slum context, where contacts with extended kin are fewer than in the rural setting, husbands appear to be particularly important. The above discussion has drawn attention to the ways in which husbands can influence decisions and behaviours relating to infant-feeding. A husband's influence may be direct, through the imposition of his will or, more commonly through discussion and negotiation with his wife on matters relating to infant-feeding. In addition, influence may be more indirect, acting through the roles of husband and wife and their relationship to one another. The study has also highlighted the fact that the sources of information and influence affecting men and women differ markedly, so that their knowledge and attitudes towards infant-feeding (as well as other issues related to child health) may diverge in important ways. These findings have important implications for programme policies aimed at improving infant-feeding practices.

Programmes that fail to recognise the importance of husbands, as well as other actors, over-simplify the situation and will be ineffective. The current emphasis on health education via field workers targeting mothers in their homes must be diversified to enable contact with other groups, in particular men. Making contact with husbands who spend long hours away from home will require innovative programme approaches. Places where men gather for work, and recreation could be targeted and used for the supply of a range of services, not just those aimed at promoting better infant-feeding. It may also be appropriate to expand the use of the mass media, which would then help combat the pervasive advertising of the milk companies.

At the same time, attempts to include husbands in programme activities aimed at improving infant-feeding practices will need to recognise

their current sources of influence and information. Husbands are exposed to more varied and potentially more inaccurate sources of information than their wives. In addition, some of these may carry great weight, such as private medical practitioners. As mentioned above, many of the men in our sample had been recommended tinned milks by private doctors. Efforts must be made to alter these sources of inaccurate information, as well as to provide alternative ways in which men can become better informed regarding their child's nutrition and health.

In the present study, many husbands referred to the feeding practices of richer households. Individuals aspire to being able to provide expensive milks and other supplements for their child. Educational campaigns should attempt to reverse the trend towards bottle-feeding among richer groups as well as the poor, and to break the association between bottle-feeding and a modern, wealthy life-style. Current promotional materials used in Bangladesh reinforce the image that breast-feeding is for poor people, while the middle-class increasingly opt for artificial supplements.

In dealing with husbands, it is also important to recognise the limited role that men currently play with respect to the provision of child care. Men must be encouraged to take greater responsibility and to support their wives in the care of their children, including breast-feeding. They must be shown ways other than the purchase and supply of tinned milks and bottles, through which to provide this necessary support.

Conclusions

The findings of the present study do not allow us to conclude simply that husbands' influence is either supportive of or detrimental to breast-feeding. Examples have been given to show how men may encourage and

support their wives to breast-feed, or equally be the promoters of early supplementation. Despite these complexities, the study findings illustrate firstly, that husbands do play a part in such decisions, whether it be directly or indirectly; and secondly, that the factors influencing their attitudes and preferences towards infant-feeding differ in several important respects from their wives. It may seem obvious to many that mothers do not act alone in the maintenance of their families, and we certainly do not suggest that the influence of men is peculiar to this setting. Nevertheless, the fact remains that the majority of child health programme activities in Bangladesh fail to recognise the importance of men.

Husbands may have the potential to be important promoters and supporters of breast-feeding, as some recent initiatives are now recognising (Haider 1994: personal communication). However, if this resource is to be utilised effectively, programmes must be designed in ways that carefully consider the roles men play both within the family and in the wider community. As Bledsoe [16] has noted, child care is never simply a matter of the relation between child and adult, it also always involves the relationships between adults. In a recent review article, Santow [17] suggests that 'probably the most useful thing that health services can [therefore] do is to look further than women. Husbands are an obvious target: bringing them into areas that are more usually viewed as the natural preserve of women, such as family planning and child health, may directly and indirectly, benefit every member of the family.' The findings from the present study suggest that husbands already exert important influences in the area of infant-feeding in the slums of urban Bangladesh and that programmes which overlook this fact are likely to be unsuccessful in their aims.

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Appendix

Case Study Household Characteristics

	Father			Mother			Child			
No.	Age[1]	Occupation	Education	Age[1]	Occupation	Education	Sex	Birth order	Feeding status	Religion
01	40	cook, government service	none	30	own household work	none	F	5	exclusive	Muslim
02	25	workshop worker	none	24	own household work	none	M	3	exclusive	Muslim
03	50	vegetable seller	none	38	own household work	none	M	6	exclusive	Muslim
04	30	small shop owner	none	23	own household work	none	F	3	exclusive	Muslim
05	28	rickshaw puller	none	22	house maid	none	M	2	exclusive	Muslim
06	22	mosaic floor maker	class 8	16	own household work	class 5	F	1	exclusive	Muslim
07	35	rickshaw puller	class 3	20-29	house maid	none	M	4	exclusive	Muslim
08	51	cleaner, government service	class 5	42	own household work	none	M	6	exclusive	Hindu
09	30	guard, government service	class 5	20-29	own household work	none	F	6	exclusive	Muslim
10	35	rickshaw puller	none	21	own household work	none	F	2	exclusive	Muslim
11	32	weaver	none	22	own household work	none	M	2	exclusive	Muslim
12	25	shoe maker	none	22	shoe maker	none	M	2	exclusive	Hindu
13	30-39	day labourer	none	30	own household work	none	F	6	exclusive	Muslim
14	20	manager, government service	class 5	17	own household work	class 3	F	1	exclusive	Muslim
15	28	small furniture shop owner	class 5	24	own household work	class 7	M	2	exclusive[2]	Muslim
16	30	rickshaw puller	class 8	26	own household work	none	F	2	not exclusive	Muslim
17	25	van gari puller for a factory	none	20	own household work	none	M	1	not exclusive	Muslim
18	45	tannery worker	none	38	sweeper, government service	none	F	7	not exclusive	Muslim
19	28	shoe salesman	none	20-29	own household work	none	F	2	not exclusive	Muslim
20	24	plastic factory worker	class 8	18	own household work	none	F	1	not exclusive	Muslim
21	30	sweeper, government service	none	23	own household work	none	M	4	not exclusive	Hindu

Case Study Household Characteristics (cont.)

	Father			Mother			Child			
No.	Age[1]	Occupation	Education	Age[1]	Occupation	Education	Sex	Birth order	Feeding status	Religion
22	41	baby taxi driver	class 5	30-39	own household work	none	M	8	not exclusive	Muslim
23	25	supervisor garments factory	class 5	22	garments factory worker	class 3	F	1	not exclusive	Muslim
24	35	mason	none	25	own household work	none	M	1	not exclusive	Muslim
25	30	shoe dyer, home based	class 8	24	shoe dyer, home based	class 5	F	2	not exclusive	Hindu
26	28	rickshaw puller	none	22	own household work	none	M	3	not exclusive	Muslim
27	53	day labourer	class 2	33	house maid	none	F	7	not exclusive	Muslim
28	35	tannery worker	none	30-39	own household work	none	M	3	not exclusive	Muslim

[1] Although probing techniques were used to establish ages the figures should be considered as estimates since respondents could not in general recall dates of birth accurately.

[2] In this case the father and mother gave divergent responses regarding the child's feeding status. The mother's response has been recorded here.

MCH-FP Extension Project (Urban) Working Papers:

1. Paljor N, Baqui AH, Lerman C, Silimperi DR. **"Reaching the Urban Poor-the Case of the Urban Volunteers in Dhaka, Bangladesh"**. September 1994
2. Baqui AH, Jamil K, Jahangir NM, Nahar Q, Paljor N, Silimperi DR. **"Urban Surveillance System-Dhaka Methods and Procedure"** September 1994
3. Jamil K, Baqui AH, Paljor N. **"Knowledge and Practice of Contraception in Dhaka Urban Slums: A Baseline Survey.** May 1993
4. Baqui AH, Paljor N, Silimperi DR. **"The Prevention and Treatment of Diarrhoea in Dhaka Slums".** May 1993
5. Laston SL. Baqui AH, Paljor N, Silimperi DR. **"Immunization Beliefs and Coverage in Dhaka Urban Slums"**. May 1993
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17. Salway S, Nahar Q, Ishaque Md. **"Alternative Ways to Feed Infants: Knowledge and Views of Men and Women in the Slums of Dhaka City.** May 1996

MCH-FP Extension Work at the Centre

An important lesson learned from the Matlab MCH-FP project is that a high CPR is attainable in a poor socioeconomic setting. The MCH-FP Extension Project (Rural) began in 1982 in two rural areas with funding from USAID to examine how elements of the Matlab programme could be transferred to Bangladesh's national family planning programme. In its first years, the Extension Project set out to replicate workplans, record-keeping and supervision, within the resource constraints of the government programme.

During 1986-89, the Centre helped the national programme to plan and implement recruitment and training, and ensure the integrity of the hiring process for an effective expansion of the work force of governmental Family Welfare Assistants. Other successful programme strategies scaled up or in the process of being scaled up to the national programme include doorstep delivery of injectable contraceptives, management action to improve quality of care, a management information system, and developing strategies to deal with problems encountered in collaborative work with local area family planning officials. In 1994, this project started family planning initiatives in Chittagong, the lowest performing division in the country.

In 1994, the Centre began an Urban MCH-FP Extension Project in Dhaka (based on its decade long experience in urban health) to provide a coordinated, cost-effective and replicable system of delivering MCH-FP services for Dhaka urban population. This important event marked an expansion of the Centre's capacity to test interventions in both urban and rural settings. The urban and rural extension projects have both generated a wealth of research data and published papers.

The Centre and USAID, in consultation with the government through the project's National Steering Committees, concluded an agreement for new rural and urban Extension Projects for the period 1993-97. Salient features include:

- To improve management, quality of care and sustainability of the MCH-FP programmes
- Field sites to use as "policy laboratories"
- Close collaboration with central and field level government officers
- Intensive data collection and analysis to assess the impact
- Technical assistance to GoB and NGO partners in the application of research findings to strengthen MCH-FP services.

The Division

The reconstituted Health and Population Extension Division (HPED) has the primary mandate to conduct operations research to scale up the research findings, provide technical assistance to NGOs and GoB to strengthen the national health and family planning programme.

The Centre has a long history of accomplishments in applied research which focuses on the application of simple, effective, appropriate and accessible health and family planning technologies to improve the health and well-being of the underserved and population-in-need. There are several projects in the Division which specialize in operations research in health, family planning, environmental health and epidemic control measures which cuts across several Divisions and disciplines in the Centre. The MCH-FP Extension Project (Rural), of course, is the Centre's established operations research project but the recent addition of its urban counterpart - MCH-FP Extension Project (Urban), as well as Environmental Health and Epidemic Control Programmes have enriched the Division with a strong group of diverse expertise and disciplines to enlarge and consolidate its operations research activities. There are several distinctive characteristics of these endeavors in relation to health services and policy research. First, the public health research activities of these Projects focus on improving programme performances which has policy implications at the national level and lessons for international audience. Secondly, these Projects incorporate the full cycle of conducting applied programmatic and policy relevant research in actual GoB and NGO service delivery infrastructures; dissemination of research findings to the highest levels of policy makers as well as recipients of the services at the community level; application of research findings to improve programme performance through systematic provision of technical assistance; and scaling-up of applicable findings from pilot phase to the national programme at Thana, Ward, District and Zonal levels both in the urban and rural settings.

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