Sharing responsibility: perceptions and awareness of male partners regarding the effects of female contraception

Masters Thesis by
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Summary

Bangladesh is a developing country with a population of 144 million people (Bangladesh Bureau of Statistics 2007). Several government and non-government organizations have programmes for fertility control; however, most programmes focus on women (Banglapedia: Reproductive health services 2000). Working with women in the field of maternal health, I have learned that they feel unwell all day long and they associate this with their female contraception use. It was these stories from women that made me curious to know about their husbands’ awareness of this issue.

There is an enormous body of research related to contraception: its usage, people’s perceptions and attitudes related to male and female contraception. However, none of these studies focus on male perception and awareness regarding female contraception and this omission made me more interested to learn about the subject. The main research question of this study is: What are men’s views regarding the effects of female (hormonal) contraception? This was a short study of six weeks and was conducted in an urban slum in Dhaka city, Bangladesh. In-depth interviews and Focus Group Discussions (FGD) were the main tools to collect information. Some participatory observation was made during informal conversations and during interviews. Data was coded and analysed using Atlas-ti software. Data was analysed from the standpoint of an interpretative and critical medical anthropological perspective with the feminist view.

Main findings of this study are that a good understanding between spouses is important in spousal communication and the decision-making process. Effects of using hormonal contraception were common among the female informants and women generally shared their complaints about contraception with their husbands. It is important to note that better spousal communication did not always help to involve men in contraception use. Rather extensive programmes for female contraception make men reluctant to use male contraception. Socialization has an influence on their perception of male involvement in the use of contraception.

Recommendation

Recommendations based on the results of this study are as follows:
- Motivating men: massive programming is needed to motivate men to use male contraception. Involving men as family health workers and implementing a nation-wide programme at a grassroots level might help to motivate men to use male contraception.

- Couple focused family planning programme: in the health information campaigns both partners, separately and jointly should be involved; also health education related to the body and fertility should be organised so that the basics of reproductive health are understood.

- Spousal counseling: a pair of health workers can do counseling for couples. Each team would have a woman and a man to talk to couples. The male counselor would talk to husbands and the female counselor would talk to wives.

- Door to door service: door-to-door service such as that currently offered for female contraception is needed for men.
Chapter 1 Introduction

1.1 Introduction

Bangladesh is a South Asian country with a population of 140.6 Million (Bangladesh Bureau of Statistics 2007) and a land size of 1,47,570 sq. km. In Bangladesh Contraceptive Prevalence Rate (CPR) is 55.8 % and unmet need for Contraception is 17.6 Percent ((Bangladesh Demographic and Health Survey 2007). The government and various donor agencies have extensive programmes to control the population. In an overview of the family planning method performance in the months of February and March, 2007, the number of oral pills acceptors had increased in one month whereas the number of both injectable contraception users and condom acceptor had decreased (Table 1). Numbers of users and acceptors of injectable contraception, oral pills and condom are marked in bold at the table since users of these methods were interviewed in this current study.

Table 1: Summary of the FP Performance for the Months of February 2007 & March 2007

<table>
<thead>
<tr>
<th>Indicators</th>
<th>February 2007</th>
<th>March 2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Total Eligible Couples (Excluding City Corporation )</td>
<td>23,533,591</td>
<td>23,707,896</td>
</tr>
<tr>
<td>Number of Total Acceptors (Excluding City Corporation )</td>
<td>16,061,718</td>
<td>15,962,124</td>
</tr>
<tr>
<td>CAR (Contraceptive Acceptance Rate)</td>
<td>68.3</td>
<td>67.3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Method Specific Acceptors (Cumulative)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Permanent Method (Male)</td>
</tr>
<tr>
<td>Permanent Method (Female)</td>
</tr>
<tr>
<td>Permanent Method (Total)</td>
</tr>
<tr>
<td>IUD (Users)</td>
</tr>
<tr>
<td>Injectable (Users)</td>
</tr>
<tr>
<td>Oral Pills (Acceptors)</td>
</tr>
<tr>
<td>Condom (Acceptors)</td>
</tr>
<tr>
<td>Implant (Norplant Users)</td>
</tr>
</tbody>
</table>

In a study of infertile women in Bangladesh, Nahar (2007) shows how a variety of funding agencies and the government emphasize fertility control and generally focus on programmes for women. Bangladesh is a patriarchal society where male involvement in reproductive health

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1 official website of Directorate General of Family Planning; available at [http://www.dgfp.gov.bd/achievements.htm](http://www.dgfp.gov.bd/achievements.htm)
programmes is not emphasized (Banglapedia: Reproductive health services 2000). However, men play a major role in the decision-making process at the family level about the use of contraception (Bankole and Singh 1998; Kamal 2000; Islam et al. 2006).

1.2 Reproductive health in Bangladesh

There are extensive programmes for reproductive health services in Bangladesh. Almost all programmes are focused on women (Banglapedia: Reproductive health services: 2000). The reason for this is that women are seen as the main users of these services and because they do not have easy access to other health services. The existing programmes focus on women's health services, family planning, safe delivery care, Essential Obstetric Care (EOC), referral services, and post-natal care. In addition, programmes also address prevention of unsafe abortion include menstrual regulation (MR), prevention of unwanted pregnancy, treatment of complications of abortion, post-abortion counselling, information and counselling for clients requiring MR (Banglapedia: Reproductive health services: 2000).

From 1972-96 after the independence of Bangladesh in 1971 the contraceptive prevalence rate (proportion of married women using contraception) increased from 4% to 49% (Banglapedia: Reproductive health services 2000). The Bangladesh Demographic and Health Survey (2007) reports that in Bangladesh 29.7% of urban women use contraceptive pills whereas the percentage of rural women using contraceptive pills is 28.1%. Among urban women in Bangladesh 6.0% use injectable contraceptive and in rural settings 7.3% do so. Use of condoms among urban men is 9.5 % and among the rural men it is 3.1% (BDHS 2007: 63). Perhaps practiced gender relationship in the society; position of men in society and family are reasons of this low prevalence rate of the use of male contraception. However, this data shows the emphasis placed on female contraception in the family planning programmes in Bangladesh.

In their work Schuler, et al. pointed out that Bangladesh family planning programmes empower women in the reproductive sphere (Schuler, et al: 1996). Authors argue that these family planning programmes empower women by increasing their mobility and women therefore are exposed to the public sphere. However, the authors also argue that in spite of empowering women, these family planning programmes fail to address the existing patriarchal system in Bangladesh (Schuler, et al. 1995). According to the study findings, women are dependent on their husbands and
this dependency is practiced as an image of gender relation in the larger society. Thus, these family planning programmes fail to involve men in reproductive health and actually reinforce women’s powerlessness.

1.3 Rationale of the study

In a session of the International Conference on Population and Development, held in Cairo in 1994, the importance of male involvement in reproductive health was highlighted. In this conference it was recommended that men should be more responsible for their sexual and reproductive behaviour as well as their family life. After 1994 a great deal more attention was given to male involvement in reproductive health, both in research and in international debate.

Although following the conference several worldwide research studies and programmes focused on men in an effort to involve them in reproductive health activities, this trend in Bangladesh is still nascent. Some research focused on male involvement in reproductive health and family planning. (Jill et al. 2008; Ashraf et al. 1999; Hossain 2003). These studies explored various reasons for poor male involvement in reproductive health programmes in Bangladesh.

In Bangladesh, working in the field of maternal health, I have heard women complain about the use of contraception. Most of them complain about feeling drowsy, weak, burning hands or body, indigestion, lack of sound sleep, increased or decreased bleeding during menstruation etc. Many of the women say they cannot perform their daily work properly due to feeling unwell most of the time. They associate these complaints with the use of contraceptives. Tina Gammeltoft has drawn attention to women’s complaints about the use of IUD (intrauterine device) in rural Vietnam. The author has analysed women’s complaints in relation to their daily distress. Gender relations in that community, daily life distress, etc. are the reasons for their sufferings and Gammeltoft argues that complaining about an IUD is an expression of daily distress by which women mark their position in the family and society (Gammeltoft 1999).

However, in the case of Bangladeshi women, because of the association between the cause of their complaints and the use of contraceptives, this study focused on the awareness of male partners about their wives’ complaints. In a patriarchal society like Bangladesh existing gender relationships have an important role in the decision-making process about the choice of
contraceptives. Thus the decision-making process regarding contraception use and men’s awareness of their spouse’s complaints was explored in this study. Since male involvement in reproductive health is not prominent in Bangladesh, this topic gave me a chance to explore how aware men are of their wives’ complaints and how they perceive their own role in the use of contraception.

1.4 Statement of problem

In rural Bangladesh contraceptive prevalence has risen noticeably; however, male involvement in using contraception is not very high (Jill et al. 2008). The International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B) has taken the initiative to initiate a doorstep-delivery system that has an enormous role in rising contraceptive use in rural Bangladesh. This group mainly promote contraceptive pills and injectable contraception for women. In Bangladesh women are significantly more likely to use the pill as compared with other modern methods because of both access and cost (Mannan 2002).

In literature various reasons are mentioned for low male involvement in reproductive health in Bangladesh. Limited availability of male contraceptives is one of the reasons for low male involvement in Bangladesh (Banglapedia: Contraception: 2000). Some studies focus on increasing male involvement in family planning programmes in Bangladesh suggesting the promotion of effective male targeting family planning programmes. According to these studies, promoting male contraception, establishing various male-only sexual clinics, and treatment-seeking behaviour by men (Ashraf A., et al 1999), wide publicity through mass-media (Hossain 2003: 29), and more fertility and family planning programmes and research (Bankole and Singh 1998) may increase male involvement in reproductive health in Bangladesh.

None of these studies focus on male perceptions regarding the effects of female contraception. Although Bangladesh has an extensive programme on family planning focused on women, male involvement in reproductive health is very low compared with female use (Banglapedia: Family Planning: 2000). This current study was aimed to explore if the husbands of women who use hormonal contraception and have complaints about the effects of female contraception were aware of these effects. Husbands’ attitudes towards these complaints and their concern were the main focus of this study. Once men’s knowledge and perception about the use of female contraception and its effects on the female body are known, this information might play a
role to involve men by using male contraception. Therefore, this study investigated whether husbands are concerned about their wives’ complaints.

1.5 Aim of the study and research question

The aim of this study was to understand men’s perceptions and awareness regarding female hormonal contraception and its effects on women. Knowing men’s awareness about the effects of female contraception might contribute to motivate them in participating more in using male contraception.

The main research question of this study was: What are men’s views regarding the use of female (hormonal) contraception? To answer this question this study explored several sub-questions. Those were as follows:

- What was the decision-making process for couples regarding the use of contraception?
- What were their sources of knowledge about both male and female contraception?
- What kind of effects do women associate with the use of hormonal contraception, and how do they express this? How do they cope with possible negative effects?
- Do their husbands know if the woman perceives any physical and/or psychological consequences from the use of contraception? How do the husbands act accordingly?
- How do men perceive their responsibilities and involvement in contraceptive use?
Chapter 2 Literature review

2.1 Effects of hormonal contraception

Several studies focus on women’s experiences regarding the use of contraception. Studies show that first-time users discontinue oral pills before the end of the first year because of side effects such as breakthrough bleeding, acne or weight gain (Stephanie et al. 2001). Other studies show effects of injectable contraception on increasing breast cancer rates, decrease in bone mass, breakthrough bleeding, hypertension, gallstone, diabetes mellitus, weight gain, headache etc. (Bigrigg et al. 1999). In a recent study Barden-O'Fallon et al. (2009) illustrate the side effects of contraception among urban women in Honduras. This study was conducted with women who use oral pills, injectable contraception and intrauterine devices (IUD). Findings from this study suggest that out of 216 injectable contraception users, 64.8% of the women experienced headaches and 46.3% of the women had spotting. On the other hand, out of 13 pill users 53.9% and 23.1% women had headaches and spotting, respectively (Barden-O'Fallon, et al 2009). In a study in Sydney with 72 women, Mills and Barclay explored the experiences of women who use hormonal contraceptives. In focus group discussions these women shared their dissatisfaction about their contraception. The authors argued that there are two dimensions of this dissatisfaction. The first dimension was dissatisfaction related to the side effects of using oral pills or an IUD. This was a common finding mentioned in the other studies above. The second dimension of dissatisfaction was limitation of choice for effective contraception. The authors argued that women who use oral pills and IUD and have side effects do not want to use these contraceptions again, which makes them feel that their choice of effective contraception is limited (Mills and Barclay 2006).

These studies show that, worldwide, some women who use oral pills or injectable contraception have complaints. Therefore this study explored a husband’s awareness and attitude about his wife’s complaints about contraception in Bangladesh.

2.2 Male involvement in contraceptive use outside Bangladesh

Worldwide a number of studies address the issue of male involvement in the use of contraceptives. Some of these studies focus on the reasons for men’s low involvement in the use of contraception whereas some studies focus on women’s perceptions regarding the use of contraception.
2.2.1 Reason behind men’s low involvement: lack of concept of family planning methods

A study in Ghana shows that a low level of male involvement in use of contraceptives is influenced by a misconception about family planning (Akafuah and Sossou 2008). One of the main findings of this study was that increasing people’s knowledge, changing attitudes, practices of family planning and reproductive decision-making can be influenced by exposure to mass-media education. Demographic factors, religion, education, types of marital relationship can also have positive impact in this regard. Another finding of the study is that the people’s lack of knowledge causes socio-cultural misconceptions. Lack of education is the reason cited for not using various family planning methods (Akafuah and Sossou 2008).

Another qualitative study with semi-structured interviews in Brazil assessed the perspectives of 20 couples who requested a vasectomy. There are several male contraceptive methods available in Brazil such as male condoms, vasectomy, etc. (Marchi et al. 2008). The finding of this study was that in general couples did not know any effective alternative contraceptive options for men other than a vasectomy. The authors argued that their subjects knew few male contraception methods and that they perceived alternatives as interfering with spontaneity and the pleasure of intercourse. However, men accepted condom use for extra-conjugal relations which would protect them from sexually transmitted diseases (Marchi et al. 2008).

A survey study in rural Maharastra, India scrutinised the reasons for couples not accepting male methods. The majority of the participants lacked the concept of family spacing and they did not take the initiative to improve their knowledge or to accept the use of a condom. There are some men who were aware of male contraceptive methods but they had little knowledge of their correct use (Balaiah et al. 1999). This study suggests that there is an urgent need for effective intervention strategies both at the community and the clinic level. Efficient counselling, motivation and provision of services in rural and remote areas are also needed.

All the cited studies focused on men’s lack of knowledge as one of the reasons for low male involvement in using family planning methods. This lack of knowledge is either about existing male contraception methods or about the correct use of them. However, none of these studies explored how men perceive female contraception and if it really has a link with male involvement in using contraception. This current study aimed to explore this link.
2.2.2 Perceptions regarding use of contraception

In a study in Brazil Carvalho et al. (2001) showed that women’s perceptions of men's participation in the use of contraception. This study showed that men use male contraceptive methods when a woman needs to temporarily interrupt the use of her contraceptive method. The authors argued that women perceive men's participation in contraception as a support for them (women) to use contraceptive methods.

This study looked at how women perceive male participation in reproductive health. However, male perception about the female contraception and its effects is not explored in this study. This current study focused on male awareness about the effects of female contraception and their perception regarding male involvement in reproductive health.

2.3 Male involvement in contraception use in Bangladesh

Several studies conducted in Bangladesh addressed the issue of male involvement in reproductive health in Bangladesh. Some of these studies focus on male involvement in reproductive health. Other studies emphasised a variety of factors that influence the decision-making process.

2.3.1 Male involvement in contraception use

A review of existing published data from numerous sources and discussions with several government and non-governmental project managers and selected males in Bangladesh showed that the proportion of strictly male family planning methods has decreased from 22% in 1975 to 14% in 1996-97 (Ashraf, et al 1999). A qualitative study shows that embarrassment exists for condom use as related to the act of coitus (Folmar 1992 in Donahoe 1996). For this reason men buy condoms outside of their neighbourhoods. Storage of condoms is another problem as hiding places are limited in typical homes in Bangladesh. (Donahoe 1996). A report from the Centre for Policy Dialogue analysed male involvement in family planning in Bangladesh. By analyzing secondary data this report showed that among other factors, historically female-based family planning programmes and a lack of concern for men’s reproductive health needs are factors that make for a low level of male involvement in family planning in Bangladesh (Hossain 2003).
The current study tried to explore men’s awareness about the effects of contraceptive used by their wives. Once their awareness about this issue is known, it might help to motivate men in participating in using male contraception.

2.3.2 Decision making

In the period between 1990 and 1996 a Demographic and Health Survey collected data in 18 developing countries, including Bangladesh, to directly compare husbands’ and wives’ attitudes toward fertility and contraception. The Survey showed that men and women desire fairly large families in the studied countries; and husbands tend to want more children than their wives and to want the next child sooner. Study findings showed that in Bangladesh 19.1% of the husbands and 11.4% of the wives wanted larger families (Bankole and Singh 1998). The authors argued that women probably have better understanding about the safety of birth spacing and therefore they take the initiative to use contraception, either for birth spacing or for limiting the family size. However, the final decision depends on their husbands and how responsive they are about these issues.

A second study in Bangladesh evaluated woman’s perceptions of their husband’s approval of family planning and it’s effect on her current and future use of modern contraception. The Demographic and Health Survey data of 1993-94 was used in this study. This study demonstrated that in some places in Bangladesh women do not use contraceptives because of their husband’s control (Kamal 2000). Thus the final decision regarding the use of contraception is taken by the husbands.

In an article titled, ‘Men’s Approval of Family Planning in Bangladesh’, Islam et al. show that although males generally approve of the use of family planning methods, women are responsible for the use of contraception. Based on quantitative data, the authors argue that factors that influence husbands’ approval of using family planning methods include men’s age and education. Young husbands (age 22-29) and those who passed a secondary level of study are more likely to use contraceptives. Access to newspaper, television, and other forms of media also influence men’s decisions regarding the use of contraception (Islam et al. 2006).
2.3.3 Spousal communication regarding use of contraception

In a report of the Population Council Bangladesh titled ‘Men and Family Planning in Bangladesh: A Review of the Literature’ Donahoe presented the existing literature related to men and family planning programmes in Bangladesh. He discussed that spousal communication among Bangladeshi couples is not common. Even though communication occurs it is not immediately after marriage; rather in some cases it takes couples five to ten years to communicate on this issue (Aziz and Maloney 1985 in Donahoe 1996).

Hossain (1998) argues that women’s education and employment are the determining factors that affect fertility and use of contraception in Bangladesh. Women’s level of education, residence in urban or rural areas, and the extent of inter-spouse communication also play a major role. Women with employment and higher education have more inter-spouse communication about contraceptives compared to those who have no employment and little education (Hossain 1998).

In a study by Kabir and Shahjahan (2007) argue that in Bangladesh spousal communication is poor and this often makes it difficult for men to understand the reproductive health problems of women. Prevailing culture and myth do not allow men to visit health facilities with their wives. Husbands do not feel comfortable taking their wives to a health facility because they do not like to discuss sexual and reproductive health issues with the service providers (Kabir and Shahjahan 2007).

These studies in Bangladesh show men’s low involvement in the decision-making process and spousal communication in regard to the use of contraception. However, men’s perceptions about the use of female hormonal contraception and its effects on the female body is not explored here. Therefore, there is a need to learn about men’s perceptions and awareness of the effects of female contraception which is the aim of this current study.

2.4 Theoretical perspective

An interpretative medical anthropological perspective was used in this study since the subject is men’s perceptions and ideas. This perspective helps to understand the meaning behind peoples’ perceptions, ideas, attitudes towards illness and treatment seeking behaviour (Good 1994). Perceptions and attitudes are influenced by the culture and society they live in. In the current study people’s knowledge about fertility, contraception, and how it works was looked at through the lens
of interpretative medical anthropology. People’s perception regarding the effects of female contraception and male involvement in reproductive health was also explored from this perspective. A critical medical anthropological perspective with a feminist view was also used in this study. One of the aspects of critical medical anthropology is that it analyses societal or structural power relation practices at various levels and the impact of social inequality on health (Good 1994). Along with other core assumptions of a feminist perspective this view provides “an acute state of awareness of the injustice women suffer from because of their sex” and tries to improve women’s lives (Acker 1994: 57). Therefore, to understand the decision-making process regarding contraceptives, a woman’s ‘responsibility’ (to avoid unwanted pregnancy) was explored using a critical medical anthropological perspective with a feminist view.

2.5 Gender aspect in this study

There is a great deal of research that addresses gender and reproductive health. A gender perspective in reproductive health considers how society and the cultural roles of men and women influence their reproductive health practices, choices and behaviours. Studies that address gender perspective in reproductive health mainly examine adolescent sexuality, HIV/ AIDS, gender-based violence and reproductive health, male involvement in reproductive health among other topics. From an anthropological perspective several issues in reproductive health have been studied. Paradigms of maternity, menstrual taboos, perception of contraception, gestation and fetal developments are a few (Hardon, et al. 2001). Generally there is a practice of considering reproductive health as a synonym for women’s health. Therefore, conducting any research on reproductive health automatically raises a question of gender relations.

Gender relations are important for understanding the process of decision-making and spousal communication regarding the use of contraception. There are many studies which have explored this relationship (Aziz, et al: 1985; Schuler, et al: 1995, 1996; Hossain: 1998; Kamal: 2000). As I mentioned above this study aimed to understand men’s awareness and role regarding the effects of contraception used by their wives. Therefore, it is important to look at the existing gender relations among the participant spouses regarding their decision-making process before exploring their awareness. Gender has an influence over the spousal communication about use of contraception, decision regarding it, choosing particular contraception, and timing use. Therefore, understanding the decision-making process about the use of contraception provides an explanation
for the existing gender relation among the couples. Gender is also important to understand husbands’ awareness and perception about their involvement. As I mentioned above there is much work that has been done in the field of gender relations and reproductive health in Bangladesh, however, this current study explored factors other than gender that had a role in decision-making and spousal communication regarding the use of contraception.

2.6 Problem analysis diagram

The concept of the study can be presented at a glance with a problem analysis diagram. In the following diagram the initial concept of current study is presented. Here it shows this current study aimed to explore the possibility of a relationship between gender and spousal communication and the decision-making process. It also aimed to explore how gender shapes the idea of sharing responsibility among the spouses. The interrelation between gender and these three factors might have an influence on women’s sharing their complaints and their husbands’ awareness regarding these complaints. Moreover, husbands’ awareness might also have a link with their perception about their own involvement in using male contraception. This current study was aimed to explore all these links and interrelations to learn about the husband’s awareness of the complaints of their wives regarding the effects of the contraception they use. However after analyzing findings of the study some other aspects came out that could be associated with this diagram. Those are presented in discussion section.

Diagram 1: Problem analysis diagram
Chapter 3 Methodology

3.1 Study site

This study took place in an urban slum in the northern part of Dhaka city, Bangladesh. The land is mainly government-owned and is situated beside Gulshan lake. There are about 17,000 households with a population of 70,000 people. On an average there are 4.5 members per household. No survey data was available regarding the level of education of the slum dwellers, socio-economic status, fertility rate, mortality rate, etc. It is apparent, however, that most of the slum dwellers have a poor socio-economic status. The main occupations for men are rickshaw pulling, hawker, working in garments factories. Women are generally occupied as housemaids or garment workers. In an informal conversation some slum dwellers informed me that this is a migratory slum. Several non-governmental organizations (NGOs), for example, Bangladesh Rural Advancement Committee (BRAC), and Marie Stopes International provide family health care, day care centres for children of working mothers, delivery huts, and primary schools for children. These NGOs also deal with reproductive health, maternal and neonatal. Although ICDDR,B has some programmes on reproductive health in some villages, it does not work actively in this slum.

3.2 Informant selection procedure

Several NGOs work in family planning projects in Bangladesh and maintain the records of participants in their programmes. Initially I planned to collect the list of women who receive contraceptives from a specific community health clinic in the slum. However, the slum where I planned to conduct my study had been razed and the community health clinic had moved. Therefore, I returned to the slum where I had previously worked because identifying a new fieldwork site, establishing rapport with the NGO workers and slum inhabitants in an unfamiliar slum would have been too time-consuming. Unfortunately, in the slum where I had previously worked, I could not obtain a list of women who did or did not use hormonal contraceptives (pills, Norplant, injectable contraception) due to official regulations. Because of their official privacy restrictions they did not allow me to look at the records of service receivers. According to the family health workers I spoke with, almost every household in that slum receives urban family health care including family planning from an NGO and therefore the vast majority of married women in that slum uses either the contraceptive pills or injectable contraception. IUD and Norplant are not commonly used family planning methods in that slum.
I visited one of the NGO offices in the slum to learn about their work and to meet the women who visited their office to receive services. These offices provided services from 8:30 in the morning to 3:00 in the afternoon. I had informal conversations with women who used oral pills and injectable contraception. I used snowball sampling to select informants for this study. Salganik & Heckathorn call snowball sampling the ‘respondent driven sampling’ (2004) and it is also used in sociological studies to find hidden people such as injection drug users or prostitutes. Although I was familiar with the slum, this is a migratory slum and many people I knew earlier had moved out from the slum. Therefore, I chose to meet women by chatting with them in the family health worker’s clinic. Initially I selected two participants for the study from a family health worker’s clinic who used oral pills. Later after interviewing them (at their houses) I asked them if they knew any other woman who used oral pills or injectable contraception. Thus with the help of these participants I selected additional respondents. Women who use oral pills or injectable contraception were interviewed in this study since these are the two most commonly used contraceptions in that slum. Once a female informant was interviewed I asked if I could interview her husband. Once she agreed, I met her husband at a time convenient for him. After sharing the objective of the study, an appointment for an interview was made with the husbands.

3.3 study population

I conducted 15 in-depth interviews in total, eight interviews with females and seven interviews with men. All respondents were couples; however, one of the husbands did not want to take part in the research for personal reasons (please see Honufa’s case). Therefore, the number of male participants was less than female participants. I interviewed women first to explore their perception regarding fertility, use of contraception, and how it works in the human body. Their complaints regarding the contraceptive they use and their feelings about their husband’s concerns were also explored through these interviews. After speaking with the wives, I interviewed their husbands to learn about their perceptions and concerns related to the above-mentioned issues. Among these eight couples, four of them used both oral pills and injectable contraception and other four used oral pills only. Women who used both oral pills and injectable contraception did not have more complaints than the women who used oral pills only. Their complaints regarding the use of oral pills and injectable contraception were different and they mentioned it separately (this is discussed in result section).
3.4 Data collection tools

3.4.1 In-depth interviews

In-depth interviews were the main tool used to collect data. In-depth interviews help to get detailed information and also allow for clarification of questions (Hardon, et al. 2001). On the basis of the research questions I constructed the checklist for the interviews. Main themes of the checklist were the decision-making process of spouses, their knowledge regarding fertility, conception and contraception, husband’s awareness related to women’s complaints and their perception regarding male involvement in reproductive health. This technique is valuable to learn individual practices and experiences. I interviewed eight couples who use hormonal contraception; however one husband did not agree to talk to me. Therefore, I interviewed eight women and seven men in their homes to explore the objective of the study. The decision making process regarding the use of contraception, its effects, coping strategies, a husband’s role and ideas about contraception in general were explored. Husbands and wives were interviewed separately to understand their experiences and perceptions on this issue. I interviewed them separately because I wanted to learn their own knowledge and perceptions. Interviewing spouses together might have led them to be influenced by one another. A few couples had a follow-up interview because after transcribing the tape, there were parts of the conversation that had to be clarified. All interviews, both male and female, took place at their houses.

3.4.2 Focus group discussion

A focus group discussion (FGD) is useful to learn different perspectives on specific issues in a short period of time (Hardon, et al. 2001). Two separate FGDs were held with additional male (6) and female (5) respondents (not included in the interview group) to obtain the community perception on the topic. Findings from the in-depth interviews were also discussed in these FGDs. Participants of the FGDs were from the same slum and nobody I contacted refused to participate. One FGD was conducted with husbands and one with wives to determine the knowledge of each group about female contraception, its side effects and the husband’s role in contraception. Male FGD took place in one of the participants’ house and the female FGD took place in one of the family health worker’s clinics, after their official hours were over.

My initial plan was to use body mapping to understand the respondents’ perceptions and knowledge about conception and fertility in a woman’s body, how hormonal contraceptives work on
fertility, and the effects of contraception in a woman’s body. However, it was not possible to use this technique due to the lack of interest of the participants. Therefore, I chose a technique of narrative story\(^2\), focusing on the objective of the study. I started with a story with the participants and then asked them to carry on that story. This technique proved successful to encourage respondents to participate in the FGDs. In both FGDs the same narrative story was used.

3.4.3 Observation

An informal observation also used in this study. Hardon et al (2001) defines observation as, ‘observation is a technique that involves systematically selecting, watching, and recording behaviour and characteristics of living beings, objects, or phenomena’ (Hardon, et al. 2001: 207). Therefore, observing people’s behaviour and daily activities can be an important tool of data collection that provides more accurate information than interviews and questionnaires. Daily conversation and non-verbal communication like body languages or facial expression also have meaning in spousal relations, which can be understood through observation rather than interviews or questionnaires. In this study, conversational style between spouses and body language was observed during informal conversation with spouses. This can be called ‘low degree of participation’ (Hardon, et al 2001: 208) where I did not participate in their conversation or activities but rather was observing what they said, how they spoke, and how they interacted with each other.

3.5 Data coding and analysis

During the fieldwork I modified the list of questions for respondents initially created for this study. After performing the initial interviews I added questions to the list. All interviews and group discussions were recorded in audio tape. Later the interviews were transcribed in Bangla, the local language. Brewer (2000) describes data analysis as a process of bringing together data, organizing it according to patterns and categories and looking for relationships within them (Brewer 2000:108). Therefore, in this study, data were coded and analysed in Atlas-ti. A code list was made on the basis of the research theme.

In terms of data analysis, there are a variety of ways of analyzing qualitative data, for instance content analysis or discourse analysis. Content analysis was used here to analyze data. Content analysis is a thematic analysis on the basis of a research question (Green and Thorogood: 2004). This

\(^2\) See annex 2b.
is a way to analyse data that represents the theme relevant to the research question. There were four themes in this research: the decision-making process, effects of using contraception, husband’s role regarding women’s complaints and people’s perception regarding men’s role in reproductive health. Therefore, research findings were analysed using these four themes. At the same time the context of the information provided was taken into account during analysis.

3.6 Reflexivity

In the context of Bangladesh, it is uncommon to talk about sexual issues. Therefore, doing research on this topic was a big challenge. Furthermore, since this study focused on male perception about the effects of female contraception, being a female researcher created a challenge for me. This study explored the perceptions and experiences of married people in Bangladesh. In this country it is unusual to talk about sexual issues with unmarried people, as I did.

It would sometimes be permissible for a student doing an academic research on sexual issues if they were linked with a recognized organization. Ramanathan, et al. describe that the omission of gendered norms is possible in an educational session as opposed to a conventional interview (1998). The author argues that informants sometimes feel friendly and give more information to an interviewer of the opposite sex if the session is educational. In this study, with my identity as a student, it was not critical to discuss sensitive issues. After the interviews and FGDs with men, most said they were happy to talk about these issues. They shared that generally it was their wives who participated in research related to these personal matters. They felt good that at least someone wanted to know about their thoughts and feelings regarding these matters. This was also reflected during group discussions. At the beginning of a discussion they addressed me as apni (a respectful address or a formal address). However, after some time they started to address me as tumi (a way to address a near or familiar one). This made me enthusiastic about my research and brought a natural flow to the discussion.

Being a Bangladeshi girl, give me a chance to understand some aspects of society as an insider. For example, some informants’ perception about male participation in using contraception as a burden to them can be linked with the socialization process in Bangladesh. In a patriarchal society like Bangladesh boys are preferred in a family (Khan & Khanum: 2000; Amin & Mariama: 1887) and girls are socialized to prioritize men in the family. Aziz et al (1985) also emphasizes on
socialization and fertility in Bangladesh. Therefore, link between socialization and informants’ perception about male involvement in using contraception as a burden was easily understandable for me.

3.7 Challenges and Limitations

One of the big challenges conducting this study was answering the question of “Why do you (researcher) need to talk with us (men)?” At first the men wondered what was the point of talking to them since the issue was about female contraception and its effects? After describing the objective of the study, they were happy to talk on the issue although some of them mentioned that this is the first time they spoke about this topic.

Another challenge was asking the men the reasons for not using male contraception, which caused me to blush. However, after the first interview I recovered from my hesitation to talk about these issues. Another problem was exploring the concept of fertility which led to the men talking about the symptoms of pregnancy in first trimester, for example, nausea, cannot eat food, etc.

It was difficult for me to ask them if they knew anything about what happens in the body in regard to fertility after having a sexual intercourse. Choosing the right words and sentence structure required a great deal of attention.

To catch the male informants for an interview was another problem. Most of the informants were day labourers. They work from very early to late evening so I had to catch them either early in the morning at around 6:30am or after their work at night around 9:30pm. The men do not have a fixed weekend to take a rest. So it was difficult to maintain a formal schedule with them during the weekend. However, once our conversations started they proceeded smoothly.

This study took place from second week of May to third week of June. Although normally this is early monsoon in Bangladesh, this year monsoon appeared late and it was remarkable hot weather during my fieldwork. After performing the first interviews I had a rash all over my body and my doctor advised me to avoid sunlight. Therefore, there was a gap in data collection for approximately ten days. After recovering I continued my fieldwork and it went well. Although males were interviewed mainly at night (around 9:30 pm), the conversation was done privately. Due to hot
weather women stayed out of the house with children. So it was easy to have conversation with male privately that time.

All participants of this study were from nuclear family. Therefore, pressure from members of the marital family to have children or birth spacing was not possible to explore here. The main limitation of this study was that it did not explore the male contraception programmes with the reproductive health programme implementers. Various NGOs work in the slum where I did my fieldwork and they mainly provide maternal health care. However, they do not have any programme for men in reproductive health. This study explored its objectives at a micro level (Hardon et al. 2001), that is to say at the household level. Since this was a small-scale study macro level exploration was not possible. Therefore, the reason(s) for NGOs not to provide male contraception was not explored.

3.8 Ethical consideration

This research considered ethical issues both at institutional and individual level. Proper channels were followed to explore preliminary information from the family health workers about the slum. To conduct this study people were informed about the research and written consent was obtained. With the consent of informants every interview was recorded. No participant was forced to take part in the study and the reason/s for not participating was also noted. In all cases pseudonyms were used as the informants did not want their identity published.

\[3\text{ See Annex 1}\]
Chapter 4 Research findings

A ‘Positive’ Story: Milon and Rohima

Milon and Rohima have been married for 13 years. Milon, aged 38, works as a taxi driver. His wife Rohima, aged 32, is a housewife. Neither of them had any formal schooling. They have two sons. The elder son is 11 years old and younger one is 5. They used condoms for the first two years before having their first son. Milon decided to use condoms as he felt Rohima should not take oral pills before having a child. Milon knew the effects of oral pills from a MBBS (Bachelor of Medicine, Bachelor of Surgery) doctor near to their slum and he did not want to bother changing pills frequently. He described the process of decision making this way:

We decided this; both of us discussed the issue (jukti korlam) and I said to her, ‘It is not possible that you will take tablet (oral contraception pills). (We) are newly (married) so it is not alright that you will take tablets. I will take responsibility of whatever pledhoti (FP method) is needed for us…’ I did not allow her to take tablets at the beginning (of married life) because I heard that sometimes they (the pills) do not suit (women’s bodies). I will take what bebstha (FP method) is needed. What’s the problem? Two years after our marriage we thought that we should have a baby now. After the birth of my eldest son I again used condoms for one year. Then I openly discussed with her and said, ‘This is not what others said; this is my own feelings that I do not like (using condom). Now you may use family planning method (bebstha nao).’ Then she started to take oral pills and continued for 2 to 4 years. Then [she stopped] and I used bebstha [condom]. This means, we have been taking care of our family planning based on our own health conditions. We use (FP method) by rotation….

After using condoms for three years, two years before their first child and one year after that, Rohima used oral pills to avoid an unwanted pregnancy. They had a discussion before changing contraception from condom to oral pills. Milon was also concerned about the effect of oral pills and asked Rohima to share if she felt any effects of taking pills. Milon described the reason of this shifting the following way:
(I) did not like (condom). It feels somewhat different (kemon kemon bhab lagey). I did not have the exact (sexual) pleasure (tripti) that one usually has. As I did not have pleasure I have some reservation (oruchi oruchi) towards it. So, I told her, ‘Now you will bebostha nao (be using FP method). Then for her, I changed to 3 types of borbi (oral contraception pills)…she had vertigo (matha gburay), felt weak (shorir durbol durbol vab), she kept being tired (klanto thakey), she slept more than before (ghum boi beshi)…so these were some of the complications that she had. We were much disturbed in those 3 months. Then, when I gave her Nordet, it suited her; she did not have any problem afterwards. This is a very simple, easily used, good poddhoti (FP method), so we use it. But I also told her, ‘If you have any problem please let me know. If you think that you do not feel good by taking the pills, amare aowaz diba (please inform me). I will switch to poddhoti (condom) again.’ So there is no misunderstanding (genjam) between us…this is how we feel about (using FP method).

After having their first son Milon used condom for one year and then Rohima took pills for three years in a row. In the mean time they changed pills three times as the first ones did not suit Rohima. Milon was aware of the effects of oral pills and he consulted with an MBBS doctor about that. After having their second son Milon used condoms again for 2 years. After that they switched to oral pills again.

Milon shared his view about male involvement in reproductive health. He feels it is a matter of male consciousness. Neither husbands nor wives should take individual responsibility for using contraception. In his words:

This (using FP) is not one should do alone. Both husband and wife should be careful and it is good if they bebostha neya (use FP method) together. For instance, being a man I can impose my wife to take necessary measures for family planning. Then she will ekta na ekta bebostha nibo (use any FP method) thinking about future of the family. This means, this is an imposition given by me. This is not fair. Her health should get consideration and this is my responsibility. When a girl is married off, her parents are no longer responsible for her life. It is the husband who should be responsible for her. If a husband does not understand this (family planning matters)
it becomes a burden for the wife. A wife can also tell her husband, ‘I do not know all this. You take care of it (family planning). This is also not good. In case of men, they [do not listen to their wives and] stay stubborn (terami koira choila jaiga). So, women have to tolerate this. This is not right. Men should not put pressure on women about this as they will stay as couple until death…it is good if both of them use family planning methods together. They should think calculate things together. When I use, she can discontinue. If I feel problems I will inform her, ‘I am having problems. You use now.’ Then she will use it and there will be no problem.

A ‘Negative’ Story: Hanif and Honufa

Hanif and Honufa have been married for 9 years. Hanif, age 27, has a tea stall. Honufa, age 24, has joined one of the NGOs as a health worker in the studied slum two years back. Both of them have studied up to the 5th grade. They have two sons, 6 and 3.5 years respectively. Honufa had a stillbirth during her first pregnancy. Honufa became pregnant after six months of their marriage. Before that she took pills for two months. She did not want to have child at that moment. She wanted to delay pregnancy, as she was a teenager. Initially Hanif agreed to wait for a child. However, after two months he wanted a child and stopped Honufa from taking pills. Honufa shared her experience following way:

At that time…9 years ago, I was very young, about 15-16 years old. Then I told my husband, ‘should I get pregnant this early. My grandmothers forbade it, everyone forbade me to get pregnant. If I get pregnant now, my health may deteriorate.’ Then he told me, ‘Ok, you take pills (borbi khao)’. Then he brought me pills. I took them for that month and the next. Afterwards, in the following month when I finished 15-20 pills he did not allow me to take them. He said, ‘No, you don’t need to take pills. I want a child.’ After hearing this I cried a lot but he did not listen to me; he did not bring me any pills more. Moreover, he did not allow me to leave this place and visit my father’s home (baaper bari).

After having a stillbirth, Honufa tried to maintain a gap for her next pregnancy. However, Hanif hardly allowed her to use any contraception. He agreed initially but after one or two months he made her to stop using contraception again. She used oral pills that time and she did not work
then. Therefore, she was dependent on her husband to bring the pills. As she had side effects from the oral pills, she switched to injectable contraception. She did not share her complaints regarding oral pills as this might lead Hanif to stop her taking the pills. According to Honufa, “if I inform my husband he will stop it right at the moment. [Laughingly] if I tell him that I am going through these problems he will not make me to take any pills. That’s why I did not inform him.” Since she did not share the effects of oral pills with her husband, Hanif’s concern regarding this could not be explored.

Honufa felt women use contraception as men are not willing to participate. She commented that men should be involved in reproductive health. She said:

Men can use condoms, can’t they? But most of the time they do not use condoms. They don’t because they say, ‘we don’t like it. It does not feel good (in having sex) with condoms [laughing]’. But men should use condoms. Because then the women need not worry and some women experience vertigo (matha ghnay) if they take borbi (pills); some women experience bleeding if they use injection. Now, for instance, I am thinking of the schedule of injections. I have to take it again. This is also true for pills; one day I take it, the other day I may not; I may forget. I may get pregnant. If pregnancy happens and if I do not want it, I may have to go through abortion (bachcha nosto koro). These are hassles. But men do not need to do all these things. That’s why I think it is better if men use a family planning method (bebosthata)... but none of the men want to take responsibility. I work for this and I talked to women. They (women) say that (their husbands say), ‘No, we do not like it.’ However, some men who are newly married say, ‘Ok. We will use condom.’ But the fact is, they use condom for 2-3 months, then stop it. Then women are bound to take borbi (contraception pills)

Hanif did not agree to take part in the research. So his view on all this issues was not explored.

Using these two stories as background I analysed the findings of this research. Let me explain why I titled these two stories as ‘positive’ and ‘negative’. Several surveys and various studies suggest that people’s education, employment, and socio-economical status have an influence on their practice and attitudes towards using family planning methods (Bankole and Singh 1998; Hossain
Studies suggest education makes people more aware of using modern family planning methods and women have a place and position to take part in the decision making process (Bankole and Singh 1998). However, these two stories do not follow that norm. In Milon and Rohima’s case, neither one has a formal education. They discussed their choices together before choosing any family planning method and they chose condoms to avoid the effects of oral pills. They used oral pills after having their first child and Milon was aware of the effects of that. He also felt that using contraception should not be a matter of only a women’s responsibility. Both husband and wife should share the responsibility of planning their sexual and reproductive lives. I see this as a positive point since in this case, education did not play a role in the discussion, decision and choice for contraception. Rather it is his personal conscience that leads this man to have a discussion with his wife, which makes him aware of his wife’s health. Moreover, his perception regarding men’s involvement also differs from others even though they do not have formal educational background. I argue his self awareness and good relation with his wife might explain his position. As there is no male family health worker and no active health education programme for men exists in that slum, the chances of being aware through this programme is very rare.

I am addressing Honufa and Hanif’s story as a negative one from another point. She did not have a job immediate after her marriage. She was dependent on her husband and at that time she discussed her plan about using contraception with her husband. Afterward, when she had a job, working as a health worker gave her the opportunity to take her own responsibility for contraception. However, at this point she did not share this with her husband. Spousal communication is missing this time. Since she did not share this decision with her husband, Honufa mentioned she always felt a fear that her husband might come to know of it and it would bring much trouble to her life. I argue it as a negative case since being a health worker, knowing about family planning, she could not practice it in her own life because of bad spousal relations. As she mentioned in the interview she encouraged women to talk to their husbands about using contraception and to decide jointly, even though she herself could not make her own husband participate in the discussion or have spousal communication regarding the use of contraception. Her job gave her support to decide to use contraception on her own but what she counselled others she could not practice in her own life because of a bad spousal relationship. Let us see what happened to the other cases.
4.1 Decision making process

4.1.1 Spousal communication and decision-making process regarding the use of contraception

Before making decisions regarding the use of contraception spousal communication was not common among the study group. In this study among the eight couples, three couples communicated with each other regarding the use of contraception. The pattern of communication also differed. It was women who initiated talking to their husbands about the use of contraception. They mainly talked on this issue after having one or two children. In the context of Bangladesh immediately after marriage a woman hardly takes part in any issues. If a woman discusses issues it is treated as bad manners towards the marital family. However, by the time a woman has one child and are accustomed to the norms and practices of the marital family they have a position of being able to take part in discussions in the family. In her study, Nahar draws attention to the importance of a child in Bangladeshi women’s lives and how they suffer both socially and psychologically if they are infertile or childless (Nahar 2007). Therefore, after having children women are allowed to express their opinion in the family about the use of contraception as well. In this study two women started a discussion with their husbands regarding the use of contraception. The first woman, Bani (age- 40, education- nil, landlord) talked to her husband about the use of contraception after she had their first child. They had a discussion regarding birth spacing and her husband offered her contraception. In her words, “When did I tell him? I think it was after my son was born. I said, ‘we are not going to have another baby. You use (condom). But he replied to me, ‘Why? You also have poddhori (female contraception methods); so you use.’”

Reasons behind not having any communication between spouses regarding the use of contraception varies from men to women. Shyness was one of the causes that restrained women from talking with their husbands regarding the use of contraception. As a newly married wife they were too shy to talk on this issue. As Shahina (age- 20, education- 3rd grade, shop owner) said, “It was right after marriage. Wouldn’t I feel shy to discuss about this. Men understand this; do I understand?” Another reason for not communicating with husbands regarding the use of contraception was lack of power to make decisions. Women mentioned that although it was a women’s issue to be pregnant or not to be, their husbands made the final decision. In that case it was not worth talking about this issue. In the FGD women also shared the same thoughts. They mentioned that hardly any discussion took place between couples. Generally husbands decided if any contraception would be used and the type of contraception. One of the participants from the women’s FGD said, “At the beginning of marriage
the husband usually take decisions, immediately after marriage. Then children are born. Discussions do n
ot take place between us; they bring (oral contraception pills) for us and we [I] just take those.”

On the other hand men felt no spousal communication was needed in this regard as their wives had confidence in them. In a patriarchal society like Bangladesh there is a traditional norm practiced where women are their husbands ‘responsibility’ after marriage. Therefore, initially it was taken for granted that whatever husbands did was good for them. In this context discussion between husband and wife regarding the use of contraception did not take place. Korim (age- 32, education-10th grade, clerk) also expressed his reason for not communicating with his wife about the use of contraception. According to him, “She doesn’t have a say. She thinks, ‘if my husband gives me any instruction he must know the background of what is good for me.’ She must have that confidence (on me).”

Husbands make the final decision regarding the use of contraception as suggested by previous studies (Bankole and Singh 1998; Kamal 2000). In addition to this core finding, this study demonstrated that there were variations in the decision-making process. Although in most cases, five among eight couples, it was the husband who decided about the use of contraception immediately after marriage, in a few cases women decided themselves. Women explained that being pregnant is a matter for the woman as a reason for taking the initiative in the decision process. Although most of the time their husbands were the main decision maker in the family, they (husbands) should not decide alone about this matter. According to Minu (age- 30, education- nil, vegetable vendor), “What will his [pointing at her child] father say? Beda manush (a male person), what can be say (on his own)? Then I was conceived with my second child. It is already hard; and it will be my sufferings if we have a child...”

At the point of choosing contraception, in most of the cases the decision was in favour of female contraception. Informants shared the idea that it was easily accessible and that they could consult with community health workers as the reason to choose female contraception. As Fayez (age- 45, education- nil, business), said, “She consulted with the doctor...you know, she also got advices from those mobila-bedi (female persons) on what will happen with which contraception. They [female health workers] said to her, ‘It is your choice. You can take borhi (contraception pills) or get an injection. Moreover there are other bebostha (FP methods) that you can also avail.’ Then I thought why should she get an injection. It is better to take borbi because it does not stop menstruation.”
With these variations in the data regarding spousal communication and decision making, I argue that gender has a strong presence in spousal communication and the decision-making process. Previous studies present the gender relation and family planning programmes in Bangladesh where, at the family level, gender is practiced as an image of gender relations at the state level (Schuler 1995; 1996; Aziz, et al. 1985). I argue that in this current study the strong existence of gender relations played a role in spousal communication and in making decisions about contraception use. Women do not initiate talking with their husbands immediate after marriage because of this gender relationship. This attempt would have a negative impression on their marital family. In the same way, most of the time husbands took decisions about the timing and types of contraception without having a discussion with their wives. I argue due to the strong presence of gender they did not feel the need to discuss this issue with their wives. However, aside from gender, the spousal relationship also has an important role here. Informally observing spousal interaction and having informal conversations with men and women, I found that the relationship between husband and wife also has an influence in spousal communication and decision making. We can take the cases of Minu and Honufa for example. Both of them are employed but there is a difference between them in terms of spousal communication and decision-making. Minu has a good relationship with her husband. The way they interacted with each other reflected a good understanding between them. In terms of using contraception, without having any communication with her husband, Minu decided herself to use contraception and her husband accepted it. On the other hand, Honufa did communicate with her husband even before having their first child; her husband did not agree to her using contraception. They do not have a smooth spousal relationship. In an informal conversation Honufa shared that her husband even beat her for simple issues. As a family health worker she encourages others to use contraception however, she cannot make her husband agree to it. The limited relationship between them creates a barrier here.

4.2 Effects of contraception, disclosure and coping strategies

4.2.1 Knowledge regarding fertility and contraception

Informants’ ideas about the formation of a fetus in woman’s womb varied. Most of them had the idea that there is a relationship between menstruation and fertility. Some women said that a fetus was formed from a clot of menstrual blood. The FGD data with women also supported this idea. Few male informants linked fertility with menstruation but could not describe how a fetus was formed. Both male and female informants used the term ‘bash parse’ to refer pregnancy. They
explained penetration as ‘bash pora’ which means ‘entering bamboo (into women)’. Some male informants explained that the combination of sperm and menstrual blood forms a fetus. One informant, Milon (age-38, education- nil, driver) described it this way, “A drop of semen get into her body which will impregnate (gorve probo); this will be place in her narei (uterus) and then gradually blood will be accumulated that will make a whole human being (fetus). This does not happen in one day. This gradually becomes a whole human being from a drop of blood to the shape of a human.”

It was interesting to know the source of knowledge regarding the use of contraception among the study group. Although in that slum several NGOs work in reproductive and maternal health, most of the informants learned about contraception from their social networks. For women it was their sister, sister-in-law, neighbours, and elder women in the family such as their mother or grandmother who informed them about the contraception. In a literature review of men and family planning programme in Bangladesh by Population Council, Donahoe mentioned that people reported radio, government workers, and television as the main source of knowledge regarding male contraception, especially for condoms (Donahoe 1996). The author also mentioned informal sources like friends and family as important sources of knowledge on this issue. This is also supported from data of this study. In the current study most of the men knew it from their married friends. In two cases men mentioned they were informed by an MBBS doctor regarding male contraception except for condoms.

4.2.2 Uses of contraception, how it works and fear regarding the use of contraception

Users of oral pills and injectable contraception were interviewed in this study as these two were the most common contraception methods used in that slum. Among eight couples, four couples used oral pills and four used both oral pills and injectable contraception. The range of taking pills as contraception was from 2 months to eight years and depended on the couple’s marital years. On the other hand, the duration of using injectable contraception was from one year to three years. In the case of oral pills most of the informants shared that they tried different brand of pills as long as that suited them. Once they had side effects from taking pills, they switched to another pills. Women who used injectable contraception had tried oral pills first. They explained that their shift from oral pills to injectable contraception was a way to get rid off ‘effects’ of taking pills and to avoid the ‘botheration’ (jhamela) of taking pills everyday. As Minu (age- 30, education- nil, vegetable vendor) said, “Whenever I took borhi (oral contraception pills) I had vertigo (matha ghuraito). Then I thought of
starting getting injection as I usually forget to take borhi everyday…You know, if I get an injection I am free for 3 months, I do not have to worry (about taking pills) [laughingly she said it].”

On the other hand, regarding the use of male contraception, almost all male informants mentioned condom. Except in one case (Milon) the duration of using condoms was from 2 days to 1 month and most of the cases use of condom was on an experimental basis. According to Selim (age- 28, education- 8th grade, driver), “We used (condoms) right after marriage. We usually do not use condoms; if we use, we do it for some days, when we felt like (to use); like 3-4 days.” Another method, injectable contraception for men, was mentioned by almost all male informants. Interestingly, in 1994 Bangladesh had patented ‘injectable intravasal contraception for men’ (Patent Number: 1002610; dated 31st August 1994 entitled "Contraceptive for use by a male") along with other countries such as India, USA, Malaysia.\(^4\) In 2003 British Broadcast Corporation (BBC) published news online regarding the invention of male injectable contraception as ‘100% effective’ and that it was under trial.\(^5\) However, none of the family health workers in this study site confirmed its use in Bangladesh. I am not even sure if this contraception exists on a commercial basis yet. It is interesting that the men I spoke to think that it does exist. Most of the informants shared informal sources of this information, such as their friends. A few informants mentioned a MBBS doctor as the source of their information for injectable contraception for men. However, none of the male informants used injectable contraception and most of them used condoms. They did not use injectable contraception because none of their friends or family members used it. They did not take the ‘risk’ of ‘first’ user. As Selim (age- 28, education- 8th grade, driver) said, “I never used it, not even I know anyone who uses it. I knew it from my friends but I don’t know if anyone uses it. I don’t want to take the risk.”

In that slum none of the NGOs provide male sterilization or vasectomy. Informants shared that they knew about it but none of their friends or family members used it. Their perception about vasectomy is discussed in later part.

As mentioned above, both male and female informants linked fertility with a connection of menstrual blood and semen. Thus to explain how contraception works in woman’s body they made the same link. Most of them mentioned that both oral pills and injectable contraception block the

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\(^4\) (web source: Center for Biomedical Engineering, Delhi: [http://indest.iitd.ac.in/tech/details.asp?id=312](http://indest.iitd.ac.in/tech/details.asp?id=312)).

\(^5\) (web source: BBC News; Health: [http://news.bbc.co.uk/2/hi/health/3167090.stm](http://news.bbc.co.uk/2/hi/health/3167090.stm))
pathway to the uterus. Therefore, menstrual blood cannot come out to meet semen to form a fetus. Some informants explained it reduces the function of both sperm and ovum. Male FGD participants also supported this data. One informant, Milon, explained that both pills and injections make sperm liquid and then it comes out through urination; thus it cannot form fetus. Two informants said they do not have any idea how contraception works in a female body.

Ullah and Humble (2006) studied the reasons behind the discontinuation of oral pills in rural Bangladesh and said the reasons were 'folk stories' and other 'misconceptions'. According to this study “Pills will not dissolve in the stomach and will remain there as it is; pills join together to form a mala or chora (these are local Bangla words meaning necklace) of snakes, scorpions or snails inside the stomach; pills combine and harden to cause a stone in the stomach or uterus” (Ullah and Humble; 2006: 117). In addition to these reasons, side effects of oral pills was another reason for discontinuing oral pills. Findings from the current study also suggested that some fears existed among the study participants regarding the use of oral pills or injectable contraception both for men and women. The most common fear was that the participants were concerned that 'using contraception might causes infertility'. Both men and women reported that taking pills continuously or using injectable contraception might cause damage to the ‘naar’ (uterus). It also causes losing eyesight. For men the fear was about losing the ‘power’ of sex and might them make physically weak. As Milon (age-38, education- nil, driver) said, “Yes, there are problems like how much I need I do not get. My health may deteriorate or I may perform very weak (in having sex) (oidik diya durbol boiya gesi).”

4.2.3 Effects of contraception, why it occurs, sharing and coping

Almost every couple linked taking oral pills with vertigo. Some of them mentioned they had vertigo after taking 1 or 2 pills whereas some mentioned it started after completing a one month course. Besides vertigo they also mentioned weakness, nausea, pain in hands and legs as the effects of using contraception. According to Shahina (age- 20, education- 3rd grade, housewife), “I never felt that bad. I understood when I felt bad after talking pills.” Those who used injectable contraception shared that they had burning hands and legs. Their main concern was that menstruation stopped. These women used oral pills before and mentioned the same effects that were described by the women who currently use oral pills. When they switched to injectable contraception they had the aforementioned effects. The women linked burning in their legs and hands to the cessation of menstruation. Very few informants explained the reasons for the side effects of using oral pills or
injectable contraception. Most of them said they it does something in the naar (uterus) but could not explain how. Only Rubiya (age- 25, edu- nil, housewife) explained the reasons of the side effects as an opposite reaction to stopping natural process. In her words, “Isn’t this a high-powered borhi (pills)? We forcefully stop gestation by taking pills….Now as we reversed pregnancy (the semen) is not going to place at the uterus (nare giya pore na). This is why after taking pills for a long time one suffers from vertigo (matha ghuray)….do you understand what I mean?”

Women generally shared their complaints with their husbands. Five among eight women shared their complaints regarding the effects of contraception with their husbands. Only in one case (Honufa) there was no sharing. Husband's concern regarding this will be discussed later. Besides husbands they also shared their complaints with neighbours, sister-in-law, and health workers. To avoid these effects of using contraception, women tried different strategies. Most of them changed their pills a couple of times to adjust to the medicine. They changed brands of oral pills from three to five times. Some women put a time gap in between taking pills. They took pills and after feeling any effects they stopped using contraception. In four cases women switched from pills to injection to adjust to the effects of oral pills. To avoid the effects of injection the women took a break from getting an injection. Once they menstruated, they started taking injections again. According to them they used the withdrawal method at that time. In the male FGD people mentioned that eating extra foods like eggs, fruits, or milk also helped to cope with the effects of contraception; however most of the couples could not afford these foods. One participant said, “You know we cannot eat properly. I wish I could eat some milk or nutritious food when I suffer from vertigo; monetary problems. Moreover we cannot afford fruits or other things.”

Gammeltoft (1999) studied women's complaints about IUD in Vietnam. She argued there is a link between these complaints and gender relation in Vietnamese society and daily sufferings of women there. Thus their complaints about IUD were the way to express their daily distress by which women mark their position in the family and society (Gammeltoft 1999). However, in this study women’s complaints were not the expression of their daily stress. Their complaints about using contraception do not make change in their daily life and in performing household activities. Therefore, their complaints are absolute about the use of contraception.
4.3 Husband’s concern about the issue

It is interesting to look at the men’s concern about their wives’ complaints. In this study although almost every wife shared her complaints with her husband, the men hardly got involved in using male contraception. In four cases, the husbands changed oral pills for their wives. Husbands argued that sometimes it took time to adjust to pills. Since they did not adjust to one pill, they tried different pills to adjust. In addition, husbands also arranged for additional food like milk or vitamins or stopped their wife from using contraception. However in one case a husband did not do anything. He, Kamal (age- 40, education- nil, hawker), mentioned it was a physical problem of his wife that she could not adjust to oral pills. In that case he did not have anything to do from outside. In his word, “Now, it did not suit her body; she has some problems in her body. What can I do from outside?”

Kabir and Shahjahan (2007) argue poor spousal communication is one of the reasons for low male participation in reproductive health. They argued that because of poor spousal communication a husband does not know about his wife’s problems and thus he cannot participate in reproductive health. However, in this study in spite of wife’s sharing their complaint with their husbands, men did not participate in using male contraception. In response to queries of why they did not use male contraception, husbands answered they did not think of it. They tried the available option they had near home and that was female contraception. As Korim (age- 32, education- 10th grade, clerk) said, “there are so many bebostha (family planning methods) for women. I didn’t even think of any other (method).” In the male FGD people said wives consult with health workers if they have effects from using contraception. However, husbands hardly get involved in it. They consult with a ‘doctor’ (pharmacy shop) and change the pills or stop the injection.

As I mentioned earlier that one of the aspects of critical medical anthropology is that it analyses societal or structural power relation practices at various levels and the impact of social inequality on health (Good 1994). With this perspective I argue that husbands’ concern and awareness about their wives complaints are the reflection of power relation that is practiced in the society. At the state level family planning programmes are mainly focused on women (Banglapedia: Reproductive health services: 2000). Importance of male involvement in reproductive health is not addressed by these programmes. Therefore, women are mainly targeted to use family planning methods. Similarly, at family level, although husbands were concerned about their wives complaints, they did not feel to participate in contraception use. They tried other family planning methods for
women or arranging some additional food for their wives to minimize their complaints. However, that did not work out. These supports from husbands did not allow women to not using contraception and thus their complaints remained. On the other hand, women targeting family planning programmes represent the inequality on target group. These also make a space for men to be reluctant using male contraception. I argue, women are using contraceptions and living with their complaints as a subject of power relation both at state and family level and the inequality on health is practiced in reproductive health in Bangladesh.

**4.4 Male involvements in reproductive health**

Informants had total different positions concerning the point of male involvement in reproductive health. Four couples mentioned men should be involved in reproductive health and four did not think they should be. In supporting male participation in reproductive health informants said that it is men who give semen to their wives. If they can protect their semen from getting into women, women do not need to use contraception. They use ‘water’ as a metaphor to explain it. As Bani (age- 40, education- nil, landlord) said, “Why do (men) use bebostha (family planning methods)? Children come from them but not from us. Now, as children come from them they should measures (of family planning). Then, we women do not need to take bebostha (FP method) or do not worry about this. And thus, our health does not get deteriorated. Now, everyone does not understand that. Now when the water [seminal fluid] is pouring from tap [men] we do not take way the bucket [uterus], we stop it [tap]. Don’t we?”

On the other hand some men also felt that men should be involved in reproductive health. They argued that since female contraception has side effects and men don’t have that, it is better that contraception be used by men. Emphasizing woman’s health Korim (age- 32, education- 10th grade, clerk) said, “I think it is better if men use bebostha (FP methods). When husband and wife want to have sexual intercourse (melamesha) and if a wife uses different bebostha, there must have side-effects in living, eating, in mobility etc. And the wife is fine if she does not use bebostha. For instance, after taking pills the wife may suffer from vertigo, headache and she cannot response to her husband’s sexual urge even if she wants to do so. And there will be no problem if man uses any of the bebostha.”

As I mentioned above, informants were equally divided in opposing positions in terms of male involvement in reproductive health. Those who were not in favour of male involvement argued that there were more options for female contraception, so male involvement was of no use. They
also emphasized the extensive publicity about female contraception. They pointed out that since health workers or doctors always suggest woman use oral pills or injectable contraception, men need not get involved. As Minu (age- 30, education- nil, vegetable vendor) said, “Don’t you see doctors always suggest women to take pills or get injection? Like this, they always give women precaution. They don’t need to do that for men.” In the FGD with men, participants explained that ideally both husband and wife should be involved in reproductive health. However they argued that female contraception is widely known whereas male contraception methods are quite limited. This is one of the reasons why male participation in reproductive health is low. Participants in the female FGD also had this opinion. Interestingly they argued that males should not be involved in reproductive health as they are already loaded with the bread winning for the family. Since women are used to staying at home and they have leisure time, it is better if they ‘bear’ the tension of using contraception. They mentioned that to their knowledge there were three types of male contraception: condom, vasectomy and injections for men. Since they never knew a husband who used an injection, they did not discuss it further. Regarding vasectomy the women mentioned that it might make men ‘weak’ both physically and mentally. And it might affect a man’s activities for earning bread for the family. Therefore, according to the women, it was not ‘practical’ for men to be sterilized. However they argued that if a wife has any side effect from contraception or any health problem, the husband should be involved in using contraception and he could use a condom in that case. The conversation in that FGD was as follows:

-Men should use (condom) when women are unable to use any poddhoti (FP method). Whatever it is, shui (injection) or borhi (oral contraception pills), they may not suit many women. Moreover, they may be sick in most of the time of the year. At that time, men should use (condom).

-And the women who do not have any problem can easily use (FP methods) and when women are able to use (FP methods), men do not need to use anything and they don’t even need that.

-We have more concerns than men. Why? Is this appropriate to put burden on the men while we do not use (it)? We stay at home all the time. We can also take rest; but they always under pressure of work. Now, should we give them another pressure? They (men) have to manage many hassles outside. And they will find another when they will come home.

In ‘Reproductive Health: Women and Men’s Shared Responsibility’ Anderson (2004) describes the importance of socialization in reproductive health. Men and women are socialized in their adolescents and they pursue this value of socialization in their sexual life as well. She argues
that there is a misconception about reproductive health. It is always treated as a woman's issue. In this book she pointed out that it is both a men and women’s responsibility to be involved in reproductive health. She emphasises the community and society’s importance in this responsibility. Aziz and Maloney (1985) also present gender and the socialization process of fertility in Bangladesh. Findings from the female FGD regarding male participation also reflected this idea. I argue that women’ socialization helped them to think that a man should not be involved in using contraception. In a patriarchal society like Bangladesh both boys and girls are socialized to internalize the importance of man in a family. Therefore, female participants in FGD also reflected their socialised idea regarding male involvement in reproductive health. Thus society shapes people's ideas about gender roles in the society.

4.5 Summary of findings

The summary of the main findings of this study is presented here. Firstly, gender relations are strongly present among the study participants. Previous studies show that in family planning programmes in Bangladesh, gender has a strong presence from the state level to the family level (Schuler 1995: 1996). This study also supports this idea. However, in addition to gender other factors have a role in spousal communication and in the process of decision-making. The relationship between spouses is also important to involve both partners in the decision-making process. If there is a better understanding between spouses, education or employment may not affect their communication on contraception use. However, in the Bangladeshi context, women do not talk about this issue immediately after marriage. Literature about this subject shows that sometimes it takes five to ten years for women to talk with their husband regarding the use of contraception (Aziz and Maloney 1985 in Donahoe 1996). However, in this study some women communicated with their husbands after having one child. The relationship between spouses made space for the couples to communicate with each other. In a patriarchal society, like Bangladesh, husbands make the final decision in family matters. However, in this study sometimes women made decisions about the use of contraception. I argue that a good spousal relationship gave space for women to decide themselves and for husbands to permit it. Lack of a good understanding between partners could make the opposite occur as in Honufa’s case.

Secondly, although there are many family planning programmes in Bangladesh, most of the informants shared that they knew about contraception from their social network. Informants in this
study told about the side effects of oral pills and injectable contraception. Effects of contraception were almost identical among the study groups. The most common effect they identified was vertigo. They also mentioned weakness, nausea, pain in hands and legs as effects of using contraception. Women linked these complaints with contraception, as they said they did not have these feelings before using contraception. Husbands also mentioned the effects of contraception that their wives complained about. In most cases women shared these complaints with their husbands. In addition to their husbands the women also shared their complaints with neighbours, sisters-in-law, and health workers. Changing pills, shifting from oral pills to injection, putting a pause in contraception use were ways women coped with these effects.

As I mentioned before, in this study most women shared their complaints with their husband. Knowing their wives’ complaints husbands changed the pills or tried to arrange for additional food such as milk or vitamins. Studies show that poor communication between spouses is one of the reasons for low male involvement in reproductive health (Kabir and Shahjahan 2007). However, in this study after having shared the complaints of contraception, most of the husbands did not participate in family planning methods. I argue that extensive programme and publicity in family planning programmes related to women made men reluctant to participate in the use of contraception. They instantly tried what they always heard. Thinking of other methods did not come to their mind. Therefore, most of the husbands knew their wives complaints, but were not aware of participating by using male contraception. Lack of mobilization and programmes related to male contraception was one of the reasons of their lack of awareness.

Finally, there is some variation in informants’ perceptions related to male participation in the use of contraception. Both men and women expressed their opinions regarding male involvement in the use of contraception. Some of them were for male involvement and some were not. Some mentioned that since semen comes from men, they should use contraception to protect unwanted pregnancy. Some also argued that men should be involved because female contraception has some effects and it affects sexual intercourse. People who did not support male involvement in using contraception said since health workers and doctors always suggest that women use contraception, men should not be involved. Interestingly some women mentioned that man should not be involved in family planning methods. They mentioned that men are already occupied with earning money for the family. Involving the men in family planning method would be an extra pressure for them. I
argue that socialization plays a role that make women think this way. One study shows socialization during adolescence plays a role in people’s life in future (Anderson 2004). In a patriarchal society like Bangladesh man are highly prioritized in the family and I argue that women’s perception about male involvement in contraception use is influenced by this socialization.
Chapter 5 Discussion and recommendations

5.1 Discussion:

The main aim of this study was to explore male awareness of the effects of hormonal contraception used by their wives. To explore this I interviewed 15 people in an urban slum in Dhaka, Bangladesh. To learn about male awareness regarding the effects of contraception used by their wives, I explored four themes under the main research question. Those were the decision-making process, effects of contraception, sharing between spouses and coping, husband’s awareness about it and how they perceived male involvement in contraceptive use.

In the following diagram the concept of current study is presented. It is a bit different from the original diagram discussed in second chapter. This difference is made on the basis of research findings. Here it shows that along with gender, a good relationship among spouses can influence spousal communication and the decision-making process. These two can also influence the idea of sharing responsibility among the spouses. The interrelation between both gender and good spousal relation and these three factors have an influence on choosing particular contraception to use. Aside these, availability of contraception and sources about people’s knowledge of contraception also play a role in choosing particular contraception. Once they choose and use female hormonal contraception and women have complaints, women share that with their husbands. This study explored husbands’ concerns about their wives’ complaints and how aware they are about the issue. However, availability or door-to-door services for female contraception also influence men not to be aware of using male contraception. Moreover, husbands’ awareness also has a link with their perception about their own involvement in using male contraception. At the same time women focused family planning programmes in the society also influence male involvement in reproductive health. In some cases socialization plays a role about people’s perception related to male involvement in reproductive health. However, I could not put socialization as a separate box to link with their perception about male involvement because it also plays a role to determine gender roles. Thus, this current study explored all these links and interrelations to learn about the husband’s awareness of the complaints of their wives regarding the effects of the contraception they use.

Diagram 2: Problem analysis diagram
Previous studies suggest that in Bangladesh gender relations are strongly present at both the state level and the family level (Schuler 1995, 1996) and this has a strong influence on spousal communication, making decisions about the use of contraception (Donahoe 1996; Kamal 2000; Islam, et al. 2006; Kabir and Shahjahan 2007). Based on the data collected, I argue that in addition to gender relations, good spousal relations also influenced spousal communication and decision-making about the use of contraception. In Bangladesh most programmes for reproductive health services are focused on women (Banglapedia: Reproductive health services: 2000). NGOs that work at the study site also had services focused on women and neonatal health. Nevertheless, important sources of knowledge regarding contraception, both male and female, were still informal. Friends and social networks played an important role to introduce individuals to the use of contraception. Effects of contraception were almost universal among the study people. Couples sharing matters related to this subject were present among the interviewees, and husbands were concerned about their wives’
complaints. However, men were not aware of participating in using a male family planning method. I argue that extensive programmes on family planning methods focussed on women make men reluctant to use male family planning methods and they use existing female-focused family planning programmes as an ‘explanation’ for not using male contraception. Thus, extensive programmes of woman reproductive health and their publicity make men unwilling to use male contraception and to participate in reproductive health.

These extensive family planning programmes focused on women, I argue, give space for men to remain unaware of male contraception alternatives. Schuler (1995) suggested that current family planning programmes failed to address the existing patriarchal system in Bangladesh. This current study also support it and I argue that for this husbands are not aware of participating in using male contraception, although they are concerned about their wives complaints. As I mentioned in the problem analysis diagram gender, both at the state and family level, has an influence on the decision-making process, and spousal communication about the use of contraception. Since at the state level women are the main target for family planning programmes, at the family level they are also targeted to use contraception. According to Bangladesh Demographic and Health Survey the oral pill is the most common contraception used in Bangladesh (Bangladesh Demographic and Health Survey 2007). Therefore, women have effects from using contraception. Although in most cases women shared their complaints with their husbands and husbands were concerned it was rare for husbands to use male contraception. I argue that gender has an influence here as well. Due to wide publicity and massive programmes on female family planning methods, men look for alternate female contraception to minimize their wives’ complaints rather than using male contraception. In spite of this, a good spousal relationship can play a role to involve men in reproductive health as we have seen in the cases of Milon- Rohima and Minu- Kamal where discussion took place before using contraception and women took decision about using contraception and husbands used condoms.

In terms of male involvement in reproductive health people’s perceptions varied among study participants. Some women and men perceived that men should be involved since there are side effects of female contraception and sperm comes from men. In contrast to this, some argued that men should not be involved in reproductive health as there are various methods for women. Interestingly, some women perceived that men should not be involved in using contraception as
they are already loaded with earning bread for the family. In a study Aziz and Maloney (1985) show the importance of gender role and concept of fertility taught in childhood among the Bangladeshi people and its influence in their future life. I argue that socialization process in Bangladesh plays a role here where both boys and girls are socialized to internalize the importance of man in a family. Thus, people’s perceptions are influenced by the society and culture.

After International Conference on Population and Development, held in Cairo in 1994, worldwide male involvement in reproductive health drew attention in both in research and programmes. Interestingly the proportion of strictly male family planning methods used by the population in Bangladesh has decreased from 22% in 1975 to 14% in 1996-97 (Ashraf et al. 1999). Even in the summary of the family planning method performance in the month of February and March 2007, it was projected that acceptance of condoms decreased in one month (please see Table 1). The Bangladesh Demographic and Health Survey (2007) reports that in Bangladesh male sterilization or vasectomy is 0.6% among urban population and 0.8% in rural. There is no mention of injection for men in the survey. Although informants mentioned injectable contraception for men and Bangladesh has patented ‘injectable intravasal contraception for men’ since 1994, (Patent Number: 1002610; dated 31st August 1994 entitled "Contraceptive for use by a male" in governmental programmes there is no mention of it (please see Table 1). Even though at present increasing male participation in family planning methods is the second highest prioritized programme in the population programme of Bangladesh government, it needs massive work for implementation.

It would be interesting to explore this issue with the policy makers and government bodies to know the current status of injectable contraception for men in Bangladesh. However, due to time constraints I was not able to do this in this current study. I hope I will explore this topic in future study.

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6 "web source: Center for Biomedical Engineering, Delhi: http://indest.iitd.ac.in/tech/details.asp?id=312"
5.2 Recommendations

Informants of this study suggested some recommendations to avoid the side effects of female contraception and for more male participation in reproductive health. Those are presented in a list below:

- Motivating men: extensive programmes are needed to motivate men to use male contraception. Involving men as family health workers and implementing a nationwide programme at the grassroots level might help to motivate men to use male contraception.
- Couple-focused FP programme: in health information campaigns both partners, separately and jointly should be involved; also health education related to the body and fertility should be organised so that basics of reproductive health are understood.
- Spousal counseling: pairs of health workers could do counseling for couples. Each team would have a woman and a man to talk to couples. Men would talk to husbands and women would talk to wives.
- Door-to-door service: door-to-door service similar to female contraception is needed for men.
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Annexes

Annex 1

Consent form

Sharing responsibility: perceptions and awareness of male partners regarding the effects of female contraception

Introduction/Purpose: I am, Sadia Chowdhury, a master’s student. I am here to conduct a study as a part of my master’s degree course. In this study I will try to understand the reasons behind choosing certain contraception and its effects. Your/ husbands concern regarding this also be studied which will enable better understanding of using some particular contraception and your perception regarding this. I would like to talk to you since you/ your wife is using (name) the contraceptive. As you are using this contraception, you can share better about it than those who do not.

Procedure: This conversation will take near about one hour or so. The conversation will take place at a convenient time and place for you. It is a totally voluntary participation. Please feel free to share if you do not want to participate. The conversation will be recorded in a tape to keep the flow of the conversation and to gather as much information as possible. After transcribing and analyzing the data, the tape will be destroyed.

Risks: You are free of any risk by participating or not participating in this study. This is a total academic study and it is not linked with any of the health services that are provided here.

Benefits: There may be no direct benefit for you by your participation in this research. The study may help to understand the reasons of choosing the particular contraception, its effects and your husband’s/ your concern regarding this.

Alternatives: You have the alternative to choose not to participate in this research. No harm will affect you if you refuse to participate.
Confidentiality: Your participation in this research will be confidential. You will be identified by pseudonym and not by your real name so that your identity and personal information will be kept as confidential as possible. The interview will take place with you alone/only in your presence. If anybody comes during our conversation, the topic for discussion will be changed. The results of this study may be published or presented at scientific meetings; however, your real name will not be mentioned there. Only pseudonym will be used to identify your cases.

Financial Information: No financial allowance will be provided for your participation. However, for the FGD participants, refreshments will be offered.

Subjects’ Rights: Your participation in this study is voluntary and you are free to withdraw at any time. You are not forced to share any information that you do not want to.

Contact Persons: If you have any question related to this study please contact with the researcher at this number: 0171 60333 43.

Consent
I agree to participate in the research described above. I understand that the interview will be audio taped. I will receive a copy of this consent form.

__________________________________  ____________________________________________
Informant’s name and date  Researcher’s name and date
Annex 2

2a Checklist for the In-depth interviews

Different issues will be explored to grasp the study objectives and to answer the research questions. Those are:

For female informants:

- General ideas about conception and their complaints
  - What does she know about conception and fertility?
  - How does contraception works?
  - Does she have any physical or psychological complaint? If yes, what are those?
  - What does she link as the cause of these complaints?
  - When did the complaints start?
  - Does she think any of these complaints are linked with the use of contraception?

- Uses of contraception
  - What contraceptive do they (couples) use?
  - How does she know about that contraception?
  - How long do they use it?
  - Are there any other contraceptive that they used? Explore use of condom, vasectomy; source of knowledge using contraception, duration etc.
  - Does she experience any effect from using contraception?

- Decision making process
  - How the use of contraception was decided? Was there any discussion between couples?
  - What was the discussion about?
  - Can she decide herself what contraceptive she will use? Why? Why not?
  - What happens if she decides?
  - Did she ever say to her husband to use some other contraception? What? Why? Why not?
  - What happen if she says?

- Effects of using contraception
  - What effects does she have for using contraception?
• How long? Immediate after using it?
• Are there any other causes that might effect so?
• Does she share with about the complaints?
• Whom does she share with about the complaints? Why? Why not?
• What is the response after sharing?
• Does her husband know about it? How? Why?
• What does she do to minimize the complaints? How?

• Women’s perceptions about the role of their husbands in reproductive health
  • Should men be involved in reproductive health? How? Why? Why not?
  • What can men do in reproductive health?
  • What would happen if they involve or do not involve?
  • How do they perceive men’s role in reproductive health?

For male informants:

• General ideas about conception and their complains
  • What does he know about conception and fertility?
  • How does contraception works?
  • Does his wife have any physical or psychological complaint? If yes, what are those?
  • What does he link as the cause of these complaints?
  • When did the complaints start?
  • Does he think any of these complaints are linked with the use of contraception?

• Uses of contraception
  • What contraceptive do they (couples) use?
  • How do they know about that contraception?
  • How long do they use it?
  • Are there any other contraceptive that they used? Explore the use of condom and vasectomy; source of knowledge using contraception, duration etc.
  • Does his wife experience any effect from using contraception?

• Decision making process
  • How the use of contraception was decided? Was there any discussion between couples?
• What was the discussion about?
• Can his wife decide what contraceptive she will use? Why? Why not?
• What happens if she decides?

• Effects of using contraception
  • Does he know if his wife has any effects for using contraception? How? Why?
  • What effects does she have for using contraception?
  • How long? Immediate after using it?
  • Are there any other causes that might effect so?
  • Why do these effect occur?
  • Does he share with about the complaints of his wife?
  • Whom does he share with about the complaints of his wife? Why? Why not?
  • What is the response after sharing?
  • How does he know about it the complaints of his wife? How? Why?
  • What does he do to minimize the complaints? How?

• Men’s perceptions about their role in reproductive health
  • Should men be involved in reproductive health? How? Why? Why not?
  • What can men do in reproductive health?
  • What would happen if they involve or do not involve?
  • How do they perceive their role in reproductive health?

Annex 2b

Checklist for FGD participants

Narrative story:

Shima and Rajib are just married. They are at their early twenties. Rajib is a day labour and Shima works as a housemaid. They live in a slum of Dhaka. Whom do they have at their home? What will happen next? Explore the following questions:

• General ideas about conception and their complains
  • What do they know about conception and fertility?
  • How does contraception works?
  • What are the major physical or psychological complaints by Shima?
  • What do they link as the cause of these complaints?
  • When did the complaints start?
- Do they think any of these complaints are linked with the use of contraception?

- **Uses of contraception**
  - What contraceptive do they (couples) use?
  - How do they know about that contraception?
  - How long do they use?
  - Are there any other contraceptive that they used? Explore the use of condom and vasectomy; source of knowledge using contraception, duration etc.
  - How do these contraception work in women body?
  - Does Shima experience any effect from using contraception?

- **Decision making process**
  - How the use of contraception is decided? Is there any discussion between couples?
  - What is the discussion about?
  - Can Shima decide what contraceptive she will use? Why? Why not?
  - What happens if she decides?

- **Effects of using contraception**
  - Does Rajib know if Shima has any effects for using contraception? How? Why?
  - What effects do they have for using contraception?
  - How long? Immediate after using it?
  - Are there any other causes that might effect so?
  - Why do these effects occur?
  - Does Shima share with anyone about the complaints?
  - Whom does she share with? Why? Why not?
  - What is the response after sharing?
  - What does Rajib do to minimize the complaints? How?

- **Men's perceptions about their role in reproductive health**
  - Should men be involved in reproductive health? How? Why? Why not?
  - What can men do in reproductive health?
  - What would happen if they involve or do not involve?
  - How do they perceive their role in reproductive health?
Annex 3

Local terminologies:

*Bash pora* - sexual intercourse, penetration

*Bash porse* - becoming pregnant

*Bebostha kora/ neya* - using family planning method

*(betago) Shada vanga* - sperm

*Borbi* - oral pills

*Dhatu* - white discharge

*Kathi, kathi vora* - using Norplant

*Melamesha/ Shamir shathe thaka* - sexual intercourse

*Potka* - condom

*Poddboti kora/ neya* - using family planning method

*Shui neya* - using injectable contraception