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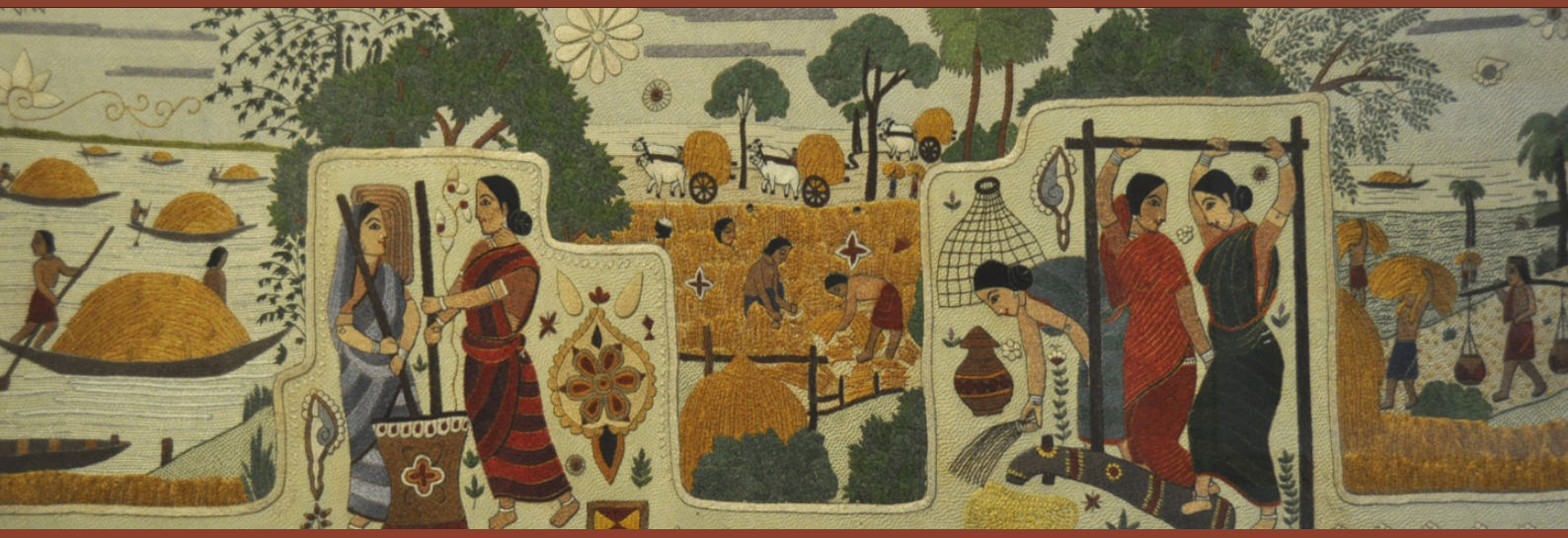

The Men Are Away: Pregnancy Risk and Family Planning Needs among Women with a Migrant Husband in Barisal, Bangladesh

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Abstract

Bangladesh is one of the major labor-exporting countries in the world, with large scale labor migration flows occurring both internationally and domestically. The 2011 Bangladesh Demographic and Health Survey suggests approximately 12% of currently married women have a husband who lives elsewhere. This study complements the 2014 Bangladesh Demographic and Health Survey (BDHS) data with qualitative exploration among a sub-sample of DHS respondents whose husbands usually stay elsewhere but return at least once a year in Barisal division, Bangladesh. The study explores how husbands' migration patterns influence couples' fertility intentions, contraceptive decision-making and behavior, and the experience of unintended pregnancies. Research methods included 23 in-depth interviews with women having migrant husbands. Results showed that contraceptive use was high in this sample, with nearly all couples using some method to avoid pregnancy, usually pills and condoms. The experience of side effects was commonplace, which contributed to a pattern of inconsistent and less effective contraceptive use: women used pills only during the duration of their husbands' visit to mitigate side effects. Half of the informants experienced unintended pregnancies either due to the failure to use the pill consistently or because the method failed. Informants lack information about menstrual regulation practices and available procedures. The study findings indicate that women with migrant husbands need family planning education and access to a wider range of family planning choices.

1. Introduction

With significant improvements in reproductive, maternal, and neonatal health, Bangladesh has made positive progress in the health and population sector over the last decade. The Bangladesh Demographic and Health Survey (BDHS) provides national estimates of nutrition, fertility, family planning, and maternal and child health in 3-year intervals. The 2014 BDHS is the seventh DHS, with data collected between July and October 2014 in a nationally representative sample of about 18,000 ever-married women of reproductive age (15-49 years).

While national surveys like Demographic and Health Surveys (DHS) provide estimates of some core indicators in health and family planning over time, they do not provide in-depth detailed information to understand population perspectives on specific behaviors and circumstances around those behaviors. For instance, according to the 2011 BDHS, 12% of women have their husbands living elsewhere but many of them make frequent visits. However, little is known about the fertility behavior of these couples. Similarly, BDHS provides estimates of many other important information, however, beliefs and perceptions related to those issues that hindered care and care seeking is not well understood. Hence, a qualitative study was attached to the 2014 BDHS to provide some additional in-depth information. Circumstances surrounding family planning use among women with migrant husbands was one the component of this qualitative study.

The broader objective of this study is to understand the nature of family planning use among women with migrant husbands, their choices and decision-making process for future pregnancies, and their perceptions about the risk of unintended pregnancy.

The specific objectives of this study are to:

- Explore women's perceptions about the risk of getting pregnant during the course of their life with a migrant husband and their use of family planning methods to delay or limit pregnancy;
- Understand the knowledge, perceptions, and attitudes surrounding unintended pregnancies; and
- Understand barriers and facilitating factors in accessing family planning and information on use of family planning methods.

2. Background and Rationale

Bangladesh has made remarkable progress in reducing fertility over the last three decades. During this period, the total fertility rate (TFR) decreased from 6.3 in the 1970s to 2.3 in 2011. Although the decline stalled in 1990s, the fertility rate began decreasing again thereafter. In the last three DHS surveys carried out in 2004, 2007, and 2011, the TFRs were 3.0, 2.7, and 2.3, respectively. During this time contraceptive prevalence rates (CPR) increased from less than 58% in 2004 to 61% in 2011 (NIPORT, Mitra and Associates, and ICF International 2013). Though indicators are indeed going in the right direction, the national CPR target (72%) has not yet been reached. To achieve the national target, the government of Bangladesh aims to reduce unmet need for family planning through increased use of contraception. Some other strategies for reaching the national CPR target, such as formulating policy for couples with seasonal migration of husbands and improving behavior change communication (BCC), have also been suggested.

Being one of the major labor-exporting countries in the world, large scale labor migration is a common phenomenon of Bangladesh. Each year a large number of people migrate overseas for both long- and short-term employment (Siddiqui 2005). Although limited information exists about the nature and causes of internal migration, people moving from rural to urban areas and one city to another city has also become a common phenomenon in Bangladesh. Many men and women leave home to find work, leading to temporary family separations.

For married couples, spousal separations due to migration for work have the potential to influence fertility and contraceptive prevalence rates. It is assumed that the length of separation disrupts both the level and timing of fertility (Massey and Mullan 1984). Neighboring Nepal has recently done a further analysis of DHS to see the effect of male migration on the contraceptive use, unmet need, and fertility. The report suggested that between 2006 and 2011 male migration was likely to be an important factor contributing to the decline in fertility in Nepal, despite stagnation in contraceptive prevalence (Khanal et al. 2013).

Spousal separation does not necessarily imply an absence of coital activity; yet, the family planning needs of temporarily separated couples differ significantly from those who are cohabiting. However, in Bangladesh family planning needs of women whose husbands are temporarily absent is difficult to ascertain due to the fact that little information exists on this topic. The DHS does a poor job of ascertaining fertility desires for this population, as it establishes unmet need from a complex set of indirect questions, rather than a single direct question. It also has two questions on desire for another child and desired timing at time of survey; and a single question about how well timed the last birth was. Similarly, there is a single question of reason for non-use of the contraception. These may not capture the complexity of fertility and pregnancy avoidance goals among women whose coital activity with their husbands is sporadic and episodic. We also do not know if women whose husbands are temporarily separated get classified (misclassified) as absent or using periodic abstinence as a traditional method.

According to the 2011 BDHS, approximately 12% of currently married women age 15-49 have a husband who lives elsewhere. This percentage is even higher in Chittagong (23%), Barisal (17%), and Sylhet (15%). Between 40% and 77% of migrant husbands return to the household at least once per year in these divisions. Contraceptive use among this group of women lags behind that of all women age 15-49 by 18-34 percentage points (NIPORT, Mitra and Associates, and ICF International 2013). Absence of husbands may be considered as a protection against pregnancy, but when husbands are away many women stop using family planning altogether. These women may be at a lower risk of pregnancy, but their contraceptive need is different. Women who stop using contraceptives when their husbands are absent may be particularly at risk if their husbands return unexpectedly (Ban et al. 2012).

Despite the potential for migration to influence fertility behavior and contraceptive use, it is not well known what are the fertility intentions of women with husbands who live elsewhere, how they perceive their risk of pregnancy, and how they manage that risk. Specifically, it is unknown whether these women have a reduced risk of pregnancy and a lower need for family planning services because of their lower coital frequency, or whether they have more complex needs for family planning that are more difficult to meet with existing services and available methods, by virtue of the intermittent presence of their husbands. Therefore, the present study aims to fill in the gaps in understanding how women with migrant husbands understand and manage their risk of getting pregnant.

3. Methodology

3.1. Research Team

The study team included nine members: three principal investigators, one co-investigator, four junior researchers, and one field assistant to assist the field research team in locating and contacting eligible participants in the field. The four junior researchers had master's degrees in anthropology. They were involved in data collection, data editing, transcription, translation of the transcripts, and coding of the data. The principal investigators and co-investigators led the data analysis and wrote the study report while the other members of the team were available to respond to any clarification needed to understand the data.

A ten-day training session was arranged before starting the field work. At the beginning of the training, a brief overview was given on the health systems and provision of services related to reproductive health in Bangladesh. The training included discussion on basic qualitative methodology and the data collection process, sampling techniques and sample selection, selection of eligible informants, ethical procedures, and field management. The main focus of the training was how to stimulate in-depth discussion on the key research questions with study informants and how best to frame those questions to collect the answers. The training included classroom discussion, role play, and field testing. Based on the experiences of field testing, interview guides were modified. Researchers were given feedback on interview techniques. An emphasis was placed on probing, note taking, transcription, translation, and writing up and elaboration of field notes. The research team was also briefed about collecting basic demographic information of the informants. The research team also had a separate 7 days training on data coding and analysis.

3.2. Research Design, Sample Size, and Field Selection

The study was qualitative in nature and designed as a companion study to the BDHS 2014. It is one of three qualitative studies attached to the BDHS 2014 and using similar methods; the results of the other studies can be found in DHS Further Analysis Reports No. 99 and No. 100.

Once the study participants were identified, in-depth, open-ended interviews were carried out following basic rules and procedures. Based on the study objectives, an interview guide was developed for in-depth, unstructured interviews. These interviews took a broad approach in the beginning, which reflected on women's lives in general and reproductive health specifically. This provided the context necessary to understand family planning use and unintended pregnancy-related experiences when living apart from the husband for the last couple of years.

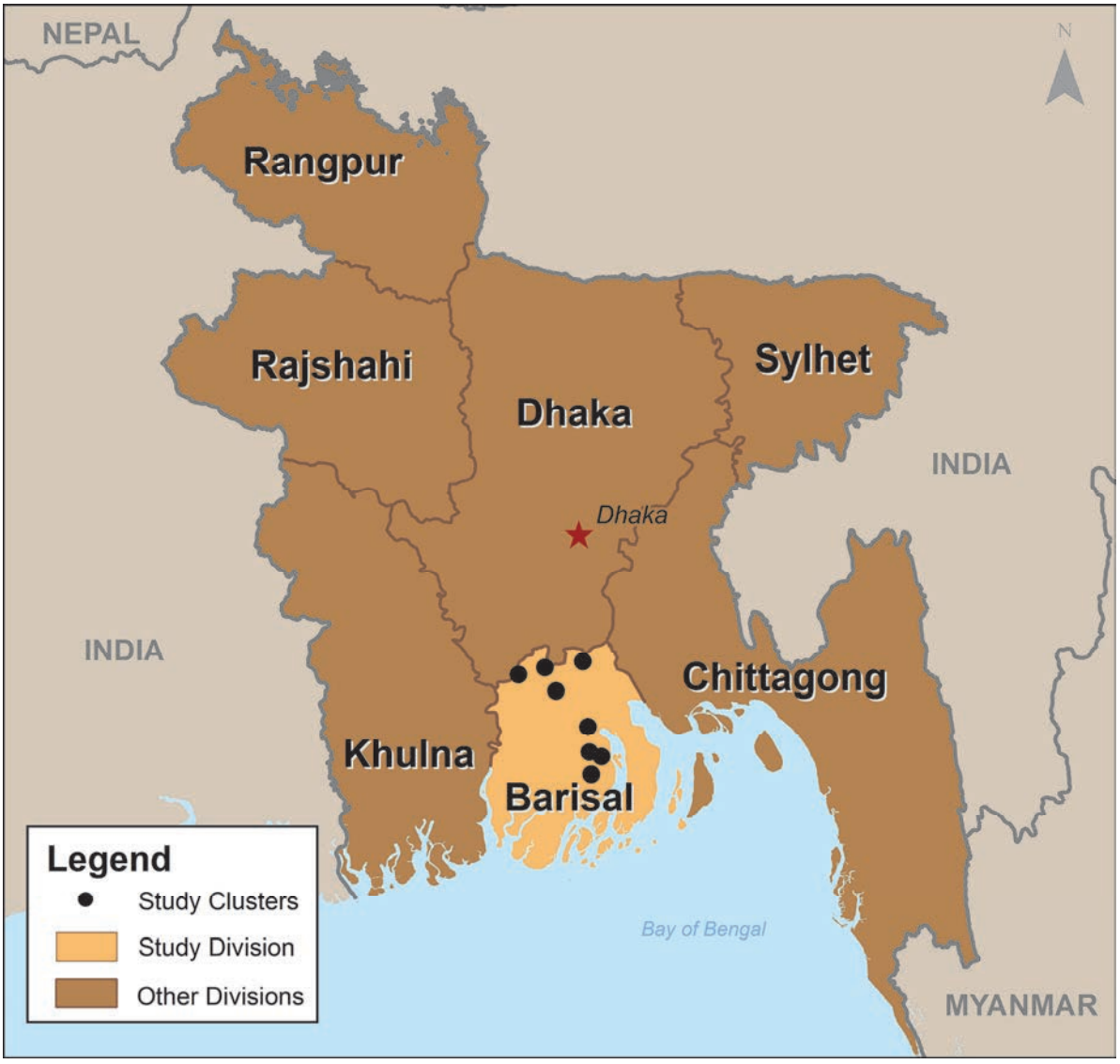
One of the main objectives of the study was to understand women's perceptions of the risk of getting pregnant during the course of their life with a migrant husband and their use of family planning to delay or limit pregnancy. More specifically, the study wanted to understand the barriers and facilitating factors in accessing family planning and information on the use of methods according to women's knowledge, perceptions, and attitudes surrounding unintended pregnancies. The sampling criteria of study population were currently married women age 15-49 whose husbands live elsewhere but made at least one visit in the last 12 months and who want to delay or prevent a (another) pregnancy. This objective guided researchers to select the study site and, within it, the study sample.

This study was conducted in selected DHS clusters in Barisal division, which had the second highest percentage of women with husbands living elsewhere. According to the 2011 BDHS, 23% of women in Chittagong division and 17% of women in Barisal division had husbands who were living elsewhere. Moreover, in Barisal, 13% of women had husbands living elsewhere who visited them at

least once in the last 12 months. The same figure was 11% for Chittagong. Barisal division was selected because of the higher percentage of women with migrant husbands who made a return visit at least once in the 12 months prior to the survey. When asked about future intention, about half of women in this situation (44%) did not want another child soon or at all, yet were not using any contraception.

The study was conducted in rural clusters as a slightly higher proportion of rural women have husbands who live elsewhere compared to urban women (12% versus 10%). In the 2014 BDHS, Barisal had 72 sample clusters (50 rural). After applying the eligibility criteria among BDHS 2011 samples to the 2014 BDHS sample estimates, a total of 166 women was estimated to be found in 50 rural clusters in Barisal (3.3 women per rural cluster).

Figure 1. Map of study division and clusters



The study planned to interview 20 to 30 women, though the overarching principle was reaching the "*point of saturation*" (Guest, Bunce, and Johnson 2006; Morse 1994; Patton 2002). The point of saturation is the point at which additional interviews yield no new analytical themes. The qualitative team received a list of 166 women living in 50 rural clusters of Barisal Division from Mitra and Associates, the implementing agency for the 2014 BDHS. From this list, a total of eight clusters were selected from two districts, namely Barisal and Potuakhali. Districts and clusters were selected

considering the geographical proximity for the researchers and availability of eligible women. In these eight clusters, 61 potentially eligible women were found and, from them, 23 women were selected for interview. It is important to mention here that each of these 61 women were reached by the researchers and interview was carried out with only those women who were available, still eligible, and interested to talk.

The qualitative study team went to the field several months after quantitative data collection for the 2014 BDHS was completed and therefore, seven women had to be excluded from the list because they had since resumed living with their husbands. Another seven women were absent from the village because they went to live with their husbands where they worked. Nine women were not at home as they were either visiting their neighbors or relatives in a distant village.

Although the 2014 BHDS quantitative survey sampled women age 15-49, the qualitative study restricted its eligibility to age 15-40 to have a clear understanding about their fertility intention. Therefore, further, five women were excluded whose age was more than 40 years. Another five women were excluded since they lived in the same household of another eligible woman. This exclusion was made to avoid repetitions of information and to protect the confidentiality of informants. Two women refused to give the interview, one woman's husband was missing and did not visit her for a long time, and one woman was excluded since her migration history was only for a short period, which may not provide a greater dimension to understand the context. Finally, one woman was excluded since she was pregnant. Therefore, at the end, 23 women were found to be eligible and available for the study.

3.3. Data Collection Procedures, Ethical Issues, and Challenges in the Fields

Once the women were identified, their names and addresses were obtained from an associated organization, Mitra and Associates, which carried out the BDHS. Before researchers went to the field, one field research assistant went to the study site with this list to identify the addresses and to make an appointment with the informants. Once the women and the family members gave the permission to be interviewed, an approximate date of interview was set and based on this appointment; researchers made a field visit to that area and conducted the interviews.

Researchers also collected short notes on general socio-economic information of the selected cluster through informal discussion with community people who were available in common places, e.g. roadside shop, yard, school, etc. These short notes were collected to understand the health facilities and other infrastructure available in the community, the distances to these facilities from the community people, and their accesses in terms of availing health services.

Interviews were administered in private settings, generally either inside the house or in the family yard. Interviews were carried out in Bangla and most interviews took from 60 to 90 minutes. All interviews were tape recorded based on the prior permission of the informants.

Ethical clearance for the project was obtained from the Ethical Review Committee (ERC) of icddr,b and ICF International's Institutional Review Board (IRB), both of which follow international ethical standards to ensure confidentiality, anonymity, and informed consent. The standard process of obtaining written informed consent was followed in the case of all participants in this research. All efforts were made to conduct the interviews in a private location and to maintain confidentiality of the information collected. It was also made clear to the informants that they had full right to refuse to respond any questions or to terminate interviews at any time if and when they want for any reason.

Even though a number of actions took place to accomplish the study, the data collection procedures encountered a number of challenges in the field. The first challenge was related to availability of informants, which has been detailed above. Besides the issues related to unavailability of informants, the data collection was delayed for 2 months due to nationwide political unrest in the country. To address all these problems, the study took various actions and made changes to the procedures used to sample the women—these procedures have been discussed in the sampling sections. Last but not least, it is important in qualitative research to make return visits to informants (often two or three times) to clarify certain aspects of the in-depth interview that may not have been understood at the first sitting. In the present study, however, it was not an option to revisit informants.

3.4. Data Management and Data Analysis

All the tape recorded interviews were transcribed verbatim (in Bangla) and all the hand written notes on the community information were expanded in Word documents immediately after coming back from the field. Investigators reviewed the transcripts generated through interviews on an ongoing basis as the data were collected, and subsequent feedback was given to the researchers. Thirty percent of interviews were translated from Bangla into English so the external principal investigator could assist in the coding, analysis, and writing up the study report.

Once the qualitative data collection was completed, a coding system was developed, capturing the main research themes and concepts generated through the data. Interviews were coded in Atlas.ti, a text-organizing software, and the data were organized according to codes or super codes developed by the research team.

After completion of the coding, a content analysis framework was developed in matrix form and the codes were organized under the broader objectives of the study (all codes were placed under the objectives where it suits best). Data triangulation was employed to identify only those concepts that could be validated and this was done through a process of assessing the validity and reliability of data. Reliability and validity in terms of qualitative research basically means how consistent (reliable) and meaningful (valid) the research results are. In other words, reliability refers to the degree to which the findings are not a result of some accidental factors of the study, and validity refers to the degree of how correctly the findings have been interpreted. For the purposes of our study, we conducted a semi-formal reliability assessment and took in a methodological consideration in order to address validity, which is triangulation.

For socio-economic information, we depended on DHS quantitative data set only for the age of the main informants for other information we used qualitative data set.

4. Results

This section of the report first describes women's/couple's socio-economic background and then discusses the patterns of husbands' migration for work. Women's perceptions, knowledge, and understanding of family planning methods and their access to different methods and information are integral to women's/couples' choice of methods and their consideration of the appropriateness of a method for couples like them. Therefore, the results section will focus on this broader issue in the next section. The later sections will focus on issues directly related to couples' use of family planning with "migrant husband" as an underlying factor, i.e., couple's interaction before the visits were made, their experiences of past and present use of family planning methods, their risk perceptions and perceptions of appropriate methods for couples including a migrant husband. Finally, this section will explain how certain methods, such as the pill—which is used by most of the informants because it is considered the appropriate method for couples to use when the husband is a migrant worker—is explained along with women's experiences of unintended pregnancy. The section also looks at issues that influence couple's decision-making from the perspective fertility control and family planning methods.

4.1. Socio-economic Background

The average age of the women in the study is 28 years; their husbands are older, with an average age of 36 years. The mean duration of marriage is 9 years while the mean age at marriage of the women was 16 years. Data suggested that compared to men, women had less educational qualifications; More women were non-literate than men and more men had higher levels of education (up to 12th grade) than women. None of the women were involved in cash earning income activities. A little less than half of the husbands were service holders in different government, private, and non-governmental organizations. The remaining husbands were involved in different types of income generating activities, which included RMG (ready-made garment) workers, drivers of different vehicles, and so on.

Most of the women (15 of 23) live in the extended family setting where almost all of them live with the mother-in-law and father-in-law, along with some having husband's sisters and brothers and their wives living with them. The remaining eight families live in a nuclear family setting since marriage. One woman separated from her in-laws recently. On average, there are two children per family.

Table 1. Socio-economic background of the women in the study (n=23)

Variables	(n=23)
Women's age in years (mean)	28 yr
Women's age at marriage in years (mean)	16 yr
Women's years of schooling	
0 years	2
1-5 years	4
6-10 years	13
12+ years	4
Women's occupation	
Housewife	23
Other	0
Husband's age in years (mean)	36 yr
Husband's years of schooling	
0 years	1
1-5 years	5
6-10 years	11
12+ years	6
Husbands' occupation	
Service holder (Govt., NGO & private)	10
Van/CNG/car driver	4
Day laborer	3
RMG worker	2
Salesmen	2
Driver (Launch)	1
Contractor	1
Mean duration (years) of work outside the home	13 yr
Mean duration (years) of marriage	11 yr
Number of visits in past year	
1-2 times	1
3-4 times	7
5-6 times	6
7-8 times	3
8+ times	6
Family type	
Nuclear	10
Extended	13
Parity (mean)	2

4.2. Husbands' Migration Patterns

Most of the husbands (16 of 23) have been living outside of the village since even before their marriages, for a duration ranging from 3 to 30 years. Consequently, the duration of marriage among these couples has a large range, as data showed that these couples were married for 3-16 years. Among the remaining seven husbands, four husbands started working outside of the village from 3-19 years ago and this was after they married. One couple was married for 4 years and the other three were married for 18-21 years. In case of the remaining three couples, the duration of marriage has a big range (2 years, 5 years, and 13 years) and they have been involved in work outside the village between 18-25 years. However, unlike other migrant couples, these women moved to their husbands' work place just after the marriage and returned home leaving the husbands there.

Almost all the husbands worked in Dhaka city or nearby Dhaka, which is approximately 230 km away from their hometown. The usual route for travelling to Dhaka is through water transport, which is cheap and accommodative for them; it is an overnight journey taking 7 hours by launch and steamer. Few informants' husbands work in the same districts or nearby districts as their hometown.

In general, the average duration of their husbands' work outside home is 13 years (3-30 years). Data suggested that more than half of the husbands visited their wives between three to six times during the last year and one fourth of the husbands visited their wives more than eight times. Most of the husbands stayed for about 1-7 days at home during their visits. Data suggested that husband's occupation type and distance to workplace had little influence on the number of visits and days of stopover period.

As mentioned earlier, three women moved to their husbands' workplace just after the marriage and started living alone after few years. The other women said that they hardly visited husbands' work place. Even if they did, it was once or twice during the entire period of migration history and most of the times it was for care seeking purposes in the district town. Almost all the husbands share their residences with other male colleagues or relatives in the work place, which was a barrier for women to make visits to their husbands frequently.

4.3. Couples' Interaction and the Implications of Mobile Phone

In this section, it will be discussed how couples communicated before the visit was made and how this communication transpires in their planning, decision-making of family planning use (*Poribar porikolpona poddhoti*), and management of family planning methods.

Most of the informants mentioned that usually their husbands communicate through mobile phones before they make any visits from their work. They also said that sudden visit, at this time of mobile phone era hardly happens.

Data suggested that at the time of interview, all the women had access to mobile phones and therefore, among other things related to the family and children's affairs, availability of family planning methods or planning for it is one of the important topics of discussion when couples make the visit plans over the phone. Women said that they usually discuss if family planning methods are available at home or not, what methods are to be used during the upcoming visit, if certain method could be used or not, considering the health condition of the women, if women would be in their safe period (e.g. point of their cycle when risk of pregnancy is lower) during that time or not, and who is going to take the responsibility of managing the method and so on.

They also mentioned that things were not as easy in the past when mobile phones were not available. Many women stated that their husbands' visits were often sudden because there was no way of

communication—in rural Bangladesh, land phone service was not available. Some husbands were able to inform their wives about their tentative visit planning through other migrating relatives and neighbors who also works in the same place. However, many women said that this process was not very helpful because immediate and timely communication on planning and preparation—in terms of obtaining a method prior to the husband's visit—was not possible through communicating with other persons.

In the sample, some women made use of mobile phones just after the marriage and some after a long time of their marriage. Data suggested that women who had mobile phones since the very beginning of their married life seldom faced unintended pregnancy while women who had faced unintended pregnancy before having access to a mobile phone, did not have such incident after they availed themselves of this communication method. There are also some outliers in the sample in terms of access to mobile phones and having unintended pregnancy. For instance, in the sample, a few women did not have any unintended pregnancy in their lives before or after they acquired mobile phones while few cases had unintended pregnancies even after they had mobile phones.

4.4. Past and Present Family Planning Method Use

In this section the informants' histories of family planning method use over the time are discussed, keeping in mind the duration and nature of their migrant husbands' visits.

The data indicate that the informants (as couples) fall into two categories. Most couples (16 of 23) started married life with the husband already being a migrant. The rest of the couples (7 of 23) started married life living together but began living apart after a few years because of the nature of the husband's work. Among the seven couples in the latter category, three women moved to their husband's work place immediately after marriage then returned home after a few years.

Most of the women whose husbands migrated after a few years of marriage are middle-aged, with a long duration of married life and three children at home (see Table 2). According to the table, there were no significant changes in the types of contraceptive methods used by these women when their husbands became migrants. For instance, three women continued to use injection after their husband's departure, while one woman was trying Norplant for few months. This finding is important because most of the women said they preferred short-term methods like the pill and condoms, due to the nature of their husbands' visits; this pattern is discussed further below. The remaining women, who began living separately from their husbands after a few years of marriage, used the pill both when they were together with their husbands and when their husbands migrated. An important change was noted in the women's pattern of pill-taking after their husbands migrated: the women now took the pill only during their husband's visits. When they were living together with their husband, they took the pill regularly on a daily basis.

Table 2 shows the history of family planning method use/non-use and the pregnancy history of each of the informants in the sample. At the top of the table, the stages mean the episode of use or non-use of methods and the pregnancy periods in the course of their reproductive life cycle until present time. The color code signifies a particular methods and the duration of using that methods while the peach color signifies their pregnancy history. A number of women used a mixture of methods, which has not been color coded as the table shows. These boxes with multiple methods means that they did not switch to one method to another but just chose to use different methods alternatively. The reasons behind such practices are discussed in further detailed below.

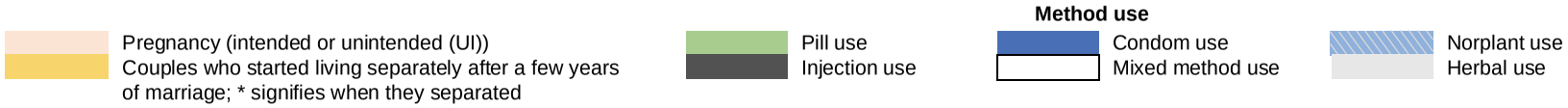
The table also shows seven informants color coded as light orange who started living separately after a few years of marriage; the asterisk (*) marks the year when they started living separately. The 14 remaining informants are living separately because they are at the beginning of their married lives.

Table 2. Use of family planning methods among married women age 15-40, by duration of marriage, Barisal, Bangladesh (n=23)

	Use of family planning methods and pregnancy history										
Informant	**1st stage**	**2nd stage**	**3rd stage**	**4th stage**	**5th stage**	**6th stage**	**7th stage**	**8th stage**	**9th stage**	**10th stage**	**11th stage**
Women married 1-5 years											
P2	P+C (1y)	Preg	I (3m)	P+C+W (2y-)							
P9	No FP (1.5y)	Preg	C+P (5m)	Preg (UI)	P (1m-)						
P4	P (6m)	Preg (UI)	P (2y)*	PC (1m)	P (2m-)						
P1	No FP (8m)	Preg	P (2.5y-)								
P18	P+C (2m)	Preg (UI)	P (2.5y-)								
P19	C (2y)	Preg (UI)	C (1.5y-)								
Women married 6-10 years											
P22	P (2.5y)	Preg	P (2.5 m-)								
P5	No FP (2.5 y)	Preg	LAM (1.5y)	Preg (UI)	I (6m)	P (1.5y-)					
P8	P (2.5y)	C (1m)	P (6 m)	Preg	P (1 y-)	I (6m)	P (1.5y-)				
P6	P (4m)	Preg (UI)	P+C+PC (2y)	Preg	P+C (3.5y)						
P17	P (7m)	Preg	I (6m)	P (3y)	Preg	P (1.5y-)					
Women married 11-20 years											
P12	No FP (1y)	Preg	I (3m)	P (4y)	No FP (4m)	Preg	P (5.5y-)				
P15	W+C (2.5y)	Preg (UI)	W+C (1.5y)	Preg	I (3m)	W+C (3.5y)	Preg	P (3.5y-)			
P23	No FP: (1.5y)	Preg	P (2.5m)	Preg	P (2.5y)	Preg	P (4y-)				
P7	No FP (1.5y)	Preg	I (1.5y)	Preg	I (3y)	P (6m)	Preg (UI)	I (3y)	Preg	I (3y-)	
P10	W (1y)	Preg (UI)	P+C+PC (2.5y)	Preg (UI)	I (1y)	C+W (4m)	N (4m)	Preg (UI)	W+C (2y)	Preg (UI)	W+C (5.5y-)
P16	No FP (3y)	Preg	P (3y)	Preg	P (1y)	H (4m)	Preg (UI)	P (3y)	I (6m)	P (2.5m-)	
P11	No FP (3y)	Preg	No FP (6m)	P (4y)	Preg*	P (3.5y)	Preg	P (4.5y-)			
P24	No FP (3m)*	Preg	LAM (1y)	Preg	LAM (1y)	Preg (UI)	I (6y)	No FP (2m)	P+C (4m)	I (3y)	C+P (6m-)
P14	PC (1.5y)	Preg	P (3m)	I (3y)	Preg	P (3y)	Preg (UI)*	I (5.5y)	P (2y)		
P3	No FP (5m)	Preg	P (1m)	I (4y)	Preg (UI)	I (3y)*	N (2m)	Preg (UI)	I (9y)	P (6m-)	
P13	No FP (3m)	Preg (UI)	P (4.5y)*	Preg	P (6y)	Preg (UI)	P (5y-)				
P21	P (2.5y)	Preg	C (2m)	P (7.5y)	Preg	C+W (6m)*	P (4m)	W (8m)	P (9.5y)	C+W (3m-)	

P=Pill, I=injection, C=Condom, N=Norplant, H=Herbal, PC[1]= *Point of Cycle* when pregnancy risk is lower (Traditional method), W=Withdrawal (Traditional method) UI=Unintended

[1] Fertility based method in which women identify the point of their cycle in which the risk of pregnancy is highest and take some action to avoid pregnancy, such as avoiding sex (periodic abstinence), using condom or withdrawal



The differences among the women in terms of the duration of their married life are very disperse and hence they were divided into three different categories: (1) women married for 1-5 years, (2) women married for 6-10 years, and (3) women married for more than 10 years. The duration of married life is important for understanding their family planning history with a migrating spouse and hence they were divided in this way. As we see in the table, the longer a woman is married, the greater the number of types of family planning methods used. For instance, it is evident from the stages of Table 2 that during the initial years of married life, women usually stick with one method and as the time goes on, they try different kinds of methods or switched from one method to another. Table 2 also suggests that most of the women used pills and injections and that have also been for a very long time in every episode, there were also a number of women/couples who used two to three types of methods simultaneously, namely, pills, condoms, and traditional methods. Table 2 also shows that condom use was more common among the youngest couples (4 of 6) in terms of marital duration compare to the oldest couples (4 of 12).

Table 2 also shows that 11 of the 23 women used something since the very beginning of their married life, however, 5 of them had unintended pregnancies. Among the remaining 12 cases, nine cases did not use any method initially to have a child and they were without a method between 1-3 years before they got pregnant. The remaining two cases said that while they were not using any method, they did not want the child during that time which means the pregnancy was mistimed.

Lastly, the table also shows that 13 of the 23 women had unintended pregnancies, including three women having two or more unintended pregnancies. Results on these issues have been elaborated later. The following section will discuss women's views and knowledge of each method and how they have influenced their practices given the context of a migrant husband.

4.4.1. Contraceptive pills

4.4.1.1. <u>Access and barriers</u>

Table 2 shows that almost all women (21) used the pill at some point in their life and 8 women used the pill as their first method over their reproductive period. Women knew the name of a number of the pill brands, such as Shukhi (the government brand of pills), as well as Femicon, Minicon, Nordate, Ovastate, and Bandan pills, and Joy foam tablets. Women reported that government brand pills are usually free while other pills cost 30 to 60 BD Taka. A few women said that the government pills are not good for a woman's body, compared to pills that are available at the market, particularly pills that are high in cost. One woman said,

> *"I learned from one of our neighbors who took government pill. She said that her baby lost his appetite. If she stopped taking pill then baby will be cured. That's why my neighbor forbids me to take government pill."*
>
> P9 (Age: 24, Years of husband's migration: 8 yr, Visited last year: 10 times, Stayed each time {average}: 7 days)

Pills were usually obtained from the various government health facilities including the Community Clinic (CC), satellite clinic, Thana Health Complex (THC), District Hospital (DH), NGO clinics working in the community, and from various government and NGO community health workers. Women either obtained pills from these sources or the health workers supplied the pills to them at home. Additionally, husbands often brought pills for their wives when they came to visit. Most pill users said that the decision/discussion about the availability of pills and the person/process used to obtain the pills generally took place right when the husband was planning a visit home. The decision was made at that time and actions transpired accordingly. Women said that often if both spouses failed to obtain pills prior to the visit—for some unavoidable situation—women obtained pills from a

neighbor or relative; also, the husband bought pills at the local market on his way home. The data appear to suggest that the husband's migration status did not add substantial barriers to the couple obtaining pills for contraceptive purposes. These points are presented in greater detail further on in the report.

Only two women reported that they had faced barriers to obtaining pills when the door-to-door health worker services were not available. Some women said that if pills are available at their door it makes the situation easier for them "if their husband did not want them to use a method." One woman said,

> *"It will be good for the women if pills are provided at door. Many men restrict their wives to use method when she does not want to be pregnant. They therefore do not use anything either (condom). What can women do in this context? Women feel shy to buy it from the market. That's why I felt it is important to have the method at home."*
>
> P24 (Age: 35, Years of husband's migration: 18 yr, Visited last year: 4 times, Stayed each time {average}: 4 days)

Confirming the above mentioned statement, another woman said that while her husband did not want her to use a method, she obtained the method on her own and used it without letting him know, delaying pregnancy for 4 years. Women also faced barriers from health care providers in obtaining their method of choice. A woman said that she did not go to her nearby depot holder for pills when her husband arrived on a sudden visit because the depot holder always proposed that she get a tubal ligation. Instead, the woman obtained a few pills from her sister-in-law.

Most women said that the community health workers or providers at various facilities usually did not provide instructions on how to take the pills correctly or inform them of any relevant suggestions when the women obtained their pills. Typically, the women learned from other pill users in the community or from the instructions on the pill packet. For women who were unable to read, the husband often helped them understand the instructions about the correct way to take the pills.

Most of the women in the sample had never heard of the emergency pill for contraception, and none of the women had used it. A few women said they knew about it from the dramas and group discussions held by NGOs as part of their maternal and neonatal health programs. These women know that the emergency pill is used when there is unprotected sudden sex, and that it works within 72 hours. One woman said that the emergency pill packet contains two or three pills that need to be taken 12 hours apart. Some women could name the two brands of emergency pills, Norex and Mcon.

4.4.1.2. <u>How contraceptive pills are used</u>

Though women/couples were very concerned about risk of getting pregnant and the fact that most women considered pill as the "appropriate method" for couples with a migrating spouse, data showed a very interesting finding regarding how women use pills.

Women know that one needed to take the pill following the arrow. They also know that pill should be started when menstruation stops, which is the last day of menstruation. In general, women knew that when a pill is missed one day, then one needs to take the pill the next day whenever she remembers and then continue taking the pill as she was doing. They knew that if one followed the rule of taking the pill every day, she would be menstruating regularly and she would not risk having unintended pregnancies. Not all the women knew what to do when the pill was missed for 2 or 3 days continuously and they understood that there was possibility of getting pregnant in such cases.

All pill users whose husbands had been working outside of home before their marriage said that they used the pill only during the time when their husbands stayed with them during their visits.

Six women, whose husbands started working outside of their home village after their marriage, said that they used to take the pill regularly before their husbands became migrant workers. However, once their husbands began migrating for work, they used the pill only during the days when their husbands came to live with them. This means that, over time, women developed their own rule in terms of using pills surrounding their husbands' visits.

Some women said that they learned this rule from health workers who assured them that using pill only during the days when husband was around would work. Some women said that they saw other women taking the pill in the same way whose husband also lived outside and hence they followed the same rule. These women said that, not only during the days when husband was around, they also took the pills for couple of more days once he left as an extra precaution. One woman said,

> *"He told to take pill just one day before doing sexual intercourse and continue it for extra 2 days after his departure."*
>
> P15 (Age: 29, Years of husband's migration: 14 yr, Visited last year: 12 times, Stayed each time {average}: 7 days)

Some women said that they also learned from the instructions in the package that there was no harm if the pill was not used for the entire month and interpreted this to mean taking pills only during the days when husbands were around and after 8 days of his departure. This woman said,

> *"It is written on the packet that one need to take the pill for the next 8 days after the departure of husband. That means, this is powerful medicines, so you have to take pill for 8 days even though you did not have intercourse. After taking 8 days, brown pill need to take to have menstruation."*
>
> P20 (Age: 18, Years of husband's migration: 2 yr, Visited last year: 3 times, Stayed each time {average}: 30 days)

Some women were very confident and said that they did not need the information on the pill packet or need to get information from others; rather, a pill user with a migrant husband can easily devise her practice from her own experience, realization, and understandings. This woman said,

> *"Apa (Health worker) told me to continue 2 days more and then leave the pill. Suppose my husband stayed one week then why should I continue the whole sheet of pill? There is no meaning to do so. People will take me differently. They will think that I might have physical relation with other man…I feel relax when my menstruation occur after my husband went away."*
>
> P15 (Age: 29, Years of husband's migration: 14 yr, Visited last year: 12 times, Stayed each time {average}: 7 days)

Another woman, even though the doctor told her to continue the entire pack of pill, did not follow the advice and said,

> *"There is a rule of doctor to take pills. The rule is pills need to be taken for the full month after the period. But I do not take it for full month. I suffer from head spinning,*

which I cannot tolerate. So I take it only while he [husband] stayed at home. I discontinue it when he leaves for his work. Doctors will say their rules. It is natural. But sometime you need to take medicines by understanding your own body..."

P18 (Age: 22, Years of husband's migration: 12 yr, Visited last year: 6 times, Stayed each time {average}: 15 days)

The data revealed that two husbands objected to their wives' use of the pill in this way. However, the women did not listen to them and continued the way they were taking the pills. One of these women said,

"*…Then my husband also said that it will be problematic for me if I take pills that way, he said to me take them every day. Initially I didn't know many things, he is more educated than me, he advised me to take every day."*

P2 (Age: 19, Years of husband's migration: 7 yr, Visited last year: 5 times, Stayed each time {average}: 5 days)

Another woman like these two said that even though her husband told her to continue the entire pill packet, the health worker suggested her to take the pill only during the days when she stayed with her husband and she followed the suggestions of health worker as she said,

"Apa said…one can choose to be menstruated or not. One who takes the entire strip of the pills as it instructed, she will be menstruating regularly. But if one takes only the white pills and start another strip avoiding the red pills from the previous strip, then she will not be menstruating. One whose husband stays at home can continue of taking pills to avoid menstruation and whose husband stay outside home can take brown pill to have period."

P23 (Age: 28, Years of husband's migration: 13 yr, Visited last year: 3 times, Stayed each time {average}: 4 days)

Women said that when they stopped taking the pill after their husband left, they menstruated automatically; this gave them confidence that the pill could be used in this way.

Some women reported that when they used a certain number of pills from a pack and then their husband left, they usually kept the pack and continued using it the next time their husband came to visit. Other women said that they started a new pack every time their husband came to visit and disposed of the remaining pills after he left.

4.4.1.3. Reasons behind switching/choosing or not choosing pill

Women often switched from one pill to another, particularly if the previous pill did not suit them or had undesirable side effects. Most pill users reported mild to severe physical problems like body ache, burning sensation, dizziness, and vomiting when using certain types of pills. This prompted them to switch to another brand. There is a widespread belief that using one brand for a long time can cause severe physical complications like cancer or paralysis. One woman said,

"I heard from my elders that it cause problem if you use a brand continuously. I was also facing dizziness with the brand I was using (Ovastate) and therefore I moved to

another brand. My husband consulted with a Dr. and he brought Femicon pill for me according to the advice of the doctor."

P1 (Age: 22, Years of husband's migration: 8 yr, Visited last year: 4 times, Stayed each time {average}: 4 days)

Physical problems associated with the pill not only resulted in switching to another pill brand but also to another method or methods. Other reasons like not wanting to use pills when women use medicines for other physical reasons (since it may affect the effectiveness of either one of them or hassles of taking too many medicines at the same time) or the fear of unintended pregnancies due to irregular use of the pill often discourage them from considering the pill as an appropriate method. Women often said that using/taking pill every day is very bothersome, which often makes them to consider other methods. Interestingly, husband's migration and periodic visits was a way for these women to avoid using pills on a regular basis, which they strategized to use only during the days when husbands are around to reduce the experience of side effects. This will be discussed below in greater detail.

Women also often switched from pill to another method from the belief that using pills for a long time may cause cancer and may cause infertility. Beliefs that the pill decreases breastmilk also prompted some women/couples to switch to a different method, which was sometimes further promoted by care providers. This woman said,

"After delivery the child depends on breastmilk. If I take pill during that time, pill must have some effect on body. If I use condom it will not put any impact on child's health. If I take pill it must be in my body and the child take milk from there. It was our perception, that's why we use condom for the last 2 months."

P21 (Age: 40, Years of husband's migration: 12 yr, Visited last year: 5 times, Stayed each time {average}: 10 days)

4.4.1.4. Perception toward the pill as an appropriate method

Most women considered the pill to be the appropriate method for a couple to use when the husband lives elsewhere. Pill users said that there was no point in using a long-term method like injection, which lasts for 3 months, when their purpose was served by the pill—a method that can be used during the days when the husband is home on a visit. One woman said,

"Why should I take that injection as he doesn't stay at home? Taking two or three pills served my purpose when he (husband) stayed at home. I know everything but do not take those as they are not applicable for me. I only use that which I need."

P23 (Age: 28, Years of husband's migration: 13 yr, Visited last year: 3 times, Stayed each time {average}: 5 days)

Additionally, pills were more accessible to women than condoms and, in cases where the husband forgot to buy pills or condoms, women could obtain pills on their own. Therefore, for many women, the pill seemed to be a better option than injection or condoms. Some women also said that the pill is more appropriate for them because it is not expensive. An injection costs 70 to 90 taka while three packs of pills can be bought for one-third of this amount. Many women cited a perceived health benefit from using the pill when their migrant husband was home on a visit. They said that because they do not use the pill for an entire month, they were less susceptible to the negative side effects that occur when the entire packet of pills is used. One woman said,

"Because my husband doesn't live with me all the time. I can take it for 2 or 3 days only and I feel fine for having it for a short time. So I prefer pill."

P14 (Age: 31, Years of husband's migration: 5 yr, Visited last year: 5 times, Stayed each time {average}: 5 days)

4.4.2. Injection

4.4.2.1. <u>Access and barriers</u>

Approximately half of the women (12 of 23) reported using injection as a family planning method at some point, and almost all women know about injection and that a dose (one injection) works for 3 months. When talking about the sources of the availability of injection, women mentioned different places e.g., government health facilities including community clinic, Thana health complex, district hospital, NGO clinics, and pharmacy or medicine shops. Some women also said that in their area, door-to-door community health workers provide injections at their homes. Some injection users said that using this method is a problem since it needs to be taken from a facility, requiring the women to physically go there. A number of women mentioned that health facilities are often far and injections are not available there all the time.

To complicate matters further, women often forget the appropriate time to take the next dose of injections. It is important to mention here that this is an overall situation to which their husbands' migration context does not make any difference in terms of women's mobility or lack of accompanying person. All these challenges often made their injection cycle irregular and women were gravely concerned they were at risk of getting pregnant at the wrong time. One woman reported having had two mistimed pregnancies—once during the unavailability of injection at hospital and the second time while she took the injection beyond the stipulated time as she could not calculate when to take the next dose. Many women believe that health workers in fact want them to take long-term methods such as tubal ligation, Copper-T, and implant instead of injections and therefore tell them injections are unavailable in the health facility. Many women said that since they were not interested to take the long-terms methods, such attitudes of the health workers made them reluctant to go to nearby health facilities or prompted them to switch to another method. All these may result in unintended pregnancies.

Women said that the cost of an injection varies from 50 to 90 BD taka. When women buy injections at a pharmacy, the price is generally 50 to 100 BD taka. An additional 10 to 20 BD taka may be needed to pay for receiving the injection at a health facility. As mentioned earlier, injections are usually free at government facilities; however, the health worker providing the injection needs to be paid a small amount as an incentive to administer the injection. Regarding the price of injection, one woman said,

"Injection is available at pharmacies. It's not free of cost. You need 70 taka for one dosage. You buy the injection for 50 taka and then you give 20 taka for pushing injection. But it is provided by government in Dhaka (husband's work station)."

P24 (Age: 35, Years of husband's migration: 18 yr, Visited last year: 5 times, Stayed each time {average}: 4 days)

Community people restrict a newlywed couple from using injection because it is thought to make the woman infertile. One woman said,

> *"Before having a baby no one takes injection method…"*
>
> P11 (Age: 35, Years of husband's migration: 19 yr, Visited last year: 12 times, Stayed each time {average}: 5 days)

Therefore, women usually use injections after having one or two children. This belief is also promoted by the health workers. Many women said that health workers restricted them from using injection just after marriage. Injections were also believed to decrease the supply of breastmilk, which meant that women do not use this method until the infant reaches a certain age if it is still dependent on breastmilk.

4.4.2.2. Reasons behind switching/choosing or not choosing injections

Perceived negative health consequences of using injection were one of the main reasons for avoiding injection, and women usually talked about bleeding, waist pain, and excessive weight gain from personal experiences with injection. Many women mentioned not menstruating for a long time due to continuous use of injection. This was a major reason for switching to another method after using injection for some years. Irregular menstruation or not menstruating at all is thought to be a bad sign for women of reproductive age. One woman said,

> *"I learned it from the elders that if menstruation doesn't occur (due to taking method) then it will help develop blood clot inside the womb and this would result into arthritis.*"
>
> P15 (Age: 29, Years of husband's migration: 14 yr, Visited last year: 12 times, Stayed each time {average}: 7 days)

Another woman said,

> *"I didn't have menstruation for 8 years for using injection. Everyone says that it is harmful for my health since menstrual blood is not good for health. Then I stopped using injection but my menstruation didn't occur. Then I went to a doctor to know if I were pregnant or not. It was negative and the he said that all these are the reaction of injection."*
>
> P24 (Age: 35, Years of husband's migration: 18 yr, Visited last year: 5 times, Stayed each time {average}: 4 days)

Along with not menstruating at all for a long period of time, women also mentioned spotting and continuous bleeding as side effect of injections. Excessive bleeding and not bleeding are considered equally harmful for women. All these beliefs surrounding injections often led women to not consider injection as a long-term method or to switch to another method, particularly the pill, after a certain period of using injection. Often women switched to another method only to have menstruation and then returned to injection. This pattern is related to a belief in the importance of relieving the menstrual blood from the body.

Like pills, injection is thought to cause serious diseases like cancer, kidney failure, or paralysis if used for a long time. This perception makes women reluctant to use injection for a long period. One woman said,

> *"People say long time use of injection is harmful. It can cause paralyses, hence I left it."*
>
> P7 (Age: 29, Years of husband's migration: 15 yr, Visited last year: 5 times, Stayed each time {average}: 7 days)

Another woman said,

> *"…It is known to all that injection is a harmful method…Injection is harmful for many women. It might create sores, it might cause cancer; some women experience excessive bleeding after taking injection. So, for all these problems women do not want to take injection."*
>
> P16 (Age: 29, Years of husband's migration: 30 yr, Visited last year: 7 times, Stayed each time {average}: 15 days)

4.4.2.3. <u>Perception toward injection as an appropriate method</u>

There were mixed feeling about injection; some did not considered it an appropriate method for women with migrant husbands; other women think that injection is only appropriate when the couple lives together regularly. In the sample, many women stopped using injection and switched to the pill for this reason, as one woman said,

> *"Do I need to take injection? He does not come home for 3 or 4 months. When he stays, pill does it for me. On the other hand, health workers do not want to give injection, rather suggested ligation, which I don't want. I had two operations and it will cause me to have another operation"*
>
> P5 (Age: 24, Years of husband's migration: 10 yr, Visited last year: 3 times, Stayed each time {average}: 30 days)

Another woman said,

> *"When husband lives apart, come after 3-4 months and stay 4-5 days, in this situation 6-7 pills is enough. I don't have to carry injection till 6 months or 9 months, or I need not to insert anything in my body. I don't need to take these types of method. Pill is good for me."*
>
> P23 (Age: 28, Years of husband's migration: 13 yr, Visited last year: 3 times, Stayed each time {average}: 5 days)

On the other hand, some other women thought that injection would be the appropriate method, which made them reassured that they were protected against the risk of pregnancy for months. One woman said,

> *"I think those women with a migrating husband should use injection. If husband gives sudden visits, then it can be a risk for the wife; contraceptive may not be available at home sometimes. In that case it is good to use injection."*
>
> P24 (Age: 35, Years of husband's migration: 18 yr, Visited last year: 5 times, Stayed each time {average}: 4 days)

One woman, comparing injection with condom said,

> *"Condom is good but also risky. Sometime my husband may forget to bring it. But in case of injection no situation can arise like that. It's for women and it is safe."*
>
> P24 (Age: 35, Years of husband's migration: 18 yr, Visited last year: 5 times, Stayed each time {average}: 4 days)

Interestingly, women who suffer a lot from use of the pill consider injection appropriate because they are released from suffering the daily dizziness and head spinning that goes along with using the pill.

4.4.3. Condoms

4.4.3.1. <u>Access and barriers</u>

A little less than half of the women (10 of 23 couples) used condoms at some point and the majority of couples used condoms along with another method, namely the pill or traditional methods. The data suggest that it was mostly the husbands who obtained the condoms, although some women obtained condoms either from the community health workers or from female relatives who use condoms. Women know that along with government and NGO health facilities, condoms are available in the pharmacies and medicine shops. However, none of the women reported ever buying condoms or obtaining them from the health facilities on their own. The data suggest that unlike other methods, women keep themselves a bit away from obtaining or managing condoms. For instance, women stated that they felt uncomfortable buying or obtaining condoms from males; as one woman said,

> *"No, no, no, are you crazy! How could I purchase it from a shop? How could a woman do that? Isn't it a matter of shame?"*
>
> P21 (Age: 40, Years of husband's migration: 12 yr, Visited last year: 5 times, Stayed each time {average}: 10 days)

Another woman said,

> *"Male doctors sit in clinics. Hence I don't go there. My husband always goes to buy condoms from there."*
>
> P24 (Age: 35, Years of husband's migration: 18 yr, Visited last year: 5 times, Stayed each time {average}: 4 days)

Many women also said that keeping or storing condoms at home for upcoming visits of the husband is often a hassle since they need to be careful to hide it from others. Women said that it is a matter of shame if others, including grown-up children, daughters-in-laws, and other family members, see the condoms at home. Women usually do not have a personal closet. Therefore, fear of others finding the condoms at home is a limitation on women's access to condoms. Avoiding such hassle is the reason women want their husbands to obtain the condoms, which is bought only for that particular visit.

The data suggest that husbands who used condoms played a very supportive role in obtaining and managing the method before they make a visit home. Husbands who used condoms frequently inquire over the phone if condoms were available at home and took the initiative, accordingly, either by bringing condoms with them or obtaining them from a near-by market once they reach their home town. The data suggest that two husbands proactively decided to use condoms because of the nature of their visits—i.e., they visited only for a short time and at irregular intervals. However, the two husbands did not use the condoms because their wives were not receptive to the method and the process of using it.

4.4.3.2. Reasons behind switching/choosing or not choosing condoms

Data suggest that many women/couples used condoms simultaneously with other methods particularly with the pill and traditional methods. These users were not regular users of any particular method; rather they use all these methods either together or one after another according to their convenience, given the nature of their husbands' visits and their menstrual/fertility cycle. For instance, if women experienced any side effect from using the pill in the previous cycle, they considered using condoms during their husband's next visit. Again, if the pill could not be managed as planned during husband's upcoming visit, a condom was considered to take care of the immediate situation. Often couples planned the visits taking into account the duration of the "safe period" because women may experience side effects from pill used and, during this time (safe period), some couples also used a condom as an extra precaution to avoid unintended pregnancy. Some women/couples used the pill and condoms simultaneously, based on the duration/number of days the couple stays together during each visit. Couples typically used condoms when the duration of the visit is short; the pill is used when husband's stay is for a longer time. One woman said,

> *"Who likes to take pill for short period? If he stayed long time then I took pill…because you need to complete the course if you take pill."*
>
> P21 (Age: 40, Years of husband's migration: 12 yr, Visited last year: 5 times, Stayed each time {average}: 10 days)

Condoms are available at the market all the time, which makes the method easier for couples to use as a stopgap measure. One woman said,

> *"When you do not have time to take medicine (contraceptive pill), you can use condom in an emergency situation. For instance, if you take the medicine now this may not work and therefore you use condom during this emergency situation…once he came suddenly during the noon time and forgot to bring medicines and during that time we used that."*
>
> P15 (Age: 29, Years of husband's migration: 14 yr, Visited last year: 12 times, Stayed each time {average}: 7 days)

On top of all these, condoms are a one-time method unlike the other methods; it takes care of each incident (intercourse) individually and is effective if used properly. This is why women/couples

choose the condom over the pill. In contrast, women said that when the pill is used, some took the pill the night when husbands arrive or some started taking the pill a couple of days before husbands' arrival; some said that the pill also needs to be continued for a couple of days after the husbands' departure as an extra precaution. These are done no matter when and how many times they have intercourse. Regarding injection, they added that injection is a three-month dosage regardless of when and how many times the husband visits them or if they do not visit them at all sometimes. Contrary to all these hassles, couples consider condoms to be a convenient method of family planning because they are readily available, cheap, and need to be used only at the time sex occurs.

Additionally, they have no health side effects. In addition to all these, women also said that this is a very appropriate method for new mothers whose child is breastfed. Other methods decrease the breastmilk supply whereas there is no such concern with this method.

However, there were also negative feelings about condoms. Women/couples often switched to injections or pill from condoms because they did not often like the condom for various reasons, e.g. decreased sexual pleasure due to lack of skin to skin contact. Often condoms were problematic to dispose of after using them. Many women also said that they worried the condom is ineffective as it could leak inside and make couple susceptible to unintended pregnancies. This woman said,

> *"Using condom is not often effective. We heard from others that some time it could leak, and you know the problem…if it leaked, it would be dangerous…this is a total loss of using the thing for which you are using it."*
>
> P21 (Age: 40, Years of husband's migration: 12 yr, Visited last year: 5 times, Stayed each time {average}: 10 days)

There are certain perceptions about condoms that often deter women from considering the method, even if it seems appropriate for couples, as mentioned earlier. Women often believe that part of a torn condom may be left inside the woman and this could be dangerous to her health. One woman said,

> *"Listen, this is my perception as I am not an infant, I can understand many things. When he pressed stoutly it could be burst and the torn pieces could do harm to her heart. Even any diseases could be happen to the women for using that. It was my own thought then I asked other about it, they said that it is ok and it doesn't burst."*
>
> P23 (Age: 28, Years of husband's migration: 13 yr, Visited last year: 3 times, Stayed each time {average}: 5 days)

4.4.3.3. <u>Knowledge on HIV/AIDS, sexually transmitted infections, and condoms</u>

Almost all the women know about HIV/AIDS and they learned about it from different sources like TV, health workers, posters in the health facility, and some from the textbooks at school. They also know that HIV/AIDS is transmitted through a sexual relationship with a person having this disease, using a needle that was used by an infected person, or taking blood from such person. Some women said that a person who had too many sexual partners usually has this disease. This woman said,

> *"If there is any diseases of husband wife may get the diseases. If husband has any extra marital sexual relation and if he did sex with the wife, there is a chance of transmit that diseases to the wife."*
>
> P23 (Age: 28, Years of husband's migration: 13 yr, Visited last year: 3 times, Stayed each time {average}: 5 days)

Some women mentioned other sexually transmitted infections (STIs) like syphilis, gonorrhea, and hepatitis that could be protected by using condom. One woman about her itching problem said,

> *"I heard about it (sexually transmitted diseases), I have it…I have itching problem. He had it and I developed it from him. I said him that I got it from him…condom using can prevent these diseases. I mean, his things wouldn't come to me and my things will not affect him as well."*
>
> P20 (Age: 18, Years of husband's migration: 2 yr, Visited last year: 3 times, Stayed each time {average}: 30 days)

Five women knew that condom could be used for protecting HIV/AIDS as one woman said,

> "*Condom can prevent the transmission of this disease. If a husband has Aids disease and he has physical relation with his wife without condom then the disease will be transmitted to his wife...it is written in a billboard at Boufal (a local NGO). The cause of this disease and signs are written on that board and I have read it while I went there."*
>
> P13 (Age: 35, Years of husband's migration: 20 yr, Visited last year: 4 times, Stayed each time {average}: 2 days)

Many couples in the sample were using condoms, however none of the women reported that they or their husband used condoms for fear of transmitting HIV or sexually transmitted infections; they said they did not have the diseases.

4.4.3.4. Perceptions toward condoms as an appropriate method

Like the pill, many women considered condoms to be an appropriate method for couples in which the husband is a migrant. Condom users said that even if the husband informed her about his visits, sometimes it is just not possible to bring pills. However, condoms are available all the time in the shop and the husband can just pick those up whenever he makes sporadic visits. One women said that considering the fact that family members often did not recommend the women to take a permanent method and the fact that all the other methods had so many side effects, condoms seemed to be the appropriate method, as she stated,

> *"There is problem (family doesn't allow taking permanent method). Then women might use pills as there is no other way. Injection does not suit to everyone, it might create problem, just as I had. Copper-T or inserting stick under arm might be other options. But these also do not suit to everyone. So I think pills or condoms are good. Pills make head spinning. But condoms are without any risk. It is to be used on spot and finished on spot. There are no difficulties in that."*
>
> P10 (Age: 35, Years of husband's migration: 21 yr, Visited last year: 10 times, Stayed each time {average}: 7 days)

4.4.4. Long-term methods

Two women adopted the implant (Norplant)—described as "*kathi/stick*" in the study—as their family planning method. However, both women had the implants removed due to severe side effects like bleeding. Interestingly, both women had an unintended pregnancy just after removal of the Norplant.

This was related to the fact the husbands were at home during the entire process and there was a delay in deciding on the next method to use.

Women said that long-term methods like the Copper-T and Norplant were available at all government health facilities, and these were usually free. In addition, the women knew that people who adopt these methods usually receive money as an incentive from the government hospital.

The data suggest that women often do not have a clear idea about the nature of long-term methods. For instances, many women said that they heard about the Copper-T from posters they had seen. They knew that it was for 10 years, however, they did not understand how to use the method properly; many said they did not know anything about the Copper-T. On the other hand, many women perceived that the Copper-T was a very complicated method because it needs to be inserted into the body "through the private parts." Many women also did not like the fact that part of it (the string) remained "outside of the body." They also had heard that the Copper-T could move inside and then a woman would need surgery to have it removed. One woman said,

> *"I am afraid of the method. It has to insert in the private part of the body. Someone will put it to my body. It can go inside the abdomen suddenly. So, it's a matter of panic."*
>
> P24 (Age: 35, Years of husband's migration: 18 yr, Visited last year: 5 times, Stayed each time {average}: 4 days)

Women have views about Norplant that are similar to those regarding the Copper-T. Like the Copper-T, Norplant is inserted in the body, though not in the private parts. However, women particularly do not like any such invasion on their body. One woman said,

> *"They will cut the arm, why should I take that pain as I do not need that? Who choose the hard method ignoring the easiest one (pill)?*
>
> P23 (Age: 18, Years of husband's migration: 13 yr, Visited last year: 3 times, Stayed each time {average}: 5 days)

As with the Copper-T, women did not have very clear idea about how Norplant works, what its duration is, or what the side effects are, although some women reported that the duration of the method is 1-5 years. Women were fearful of using this method because of the invasive procedures if it is necessary to remove the Norplant because of side effects. Women mentioned hearing about excessive bleeding, weight gain, and severe neck and muscle pains as side effects of the use of Norplant.

Women's knowledge and understanding of long-term contraceptive methods indicates strong negative views toward Norplant and Copper-T. There were three women who thought that Norplant could be an appropriate method provided women faced no side effects. They thought that instead of having the hassle of obtaining short-term methods at the time of the husband's visit, it would be better to use a long-term method and be relaxed the rest of the time. One woman said,

> *"Often the husband does not bring the method or forgot to bring the method and therefore it became so risky for the women and therefore it is appropriate to use the kathi (stick/Norplant) and Copper-T"*

P22 (Age: 22, Years of husband's migration: 8 yr, Visited last year: 4 times, Stayed each time {average}: 15 days)

Repeating the feeling once again, however, many women did not like the invasive procedures of these two methods and therefore, even if they wanted to take a method for a long time, this issue prompted them to reconsider. This woman said,

"I saw two or three women using Norplant. I don't see any problem. People use to say that Norplant gradually make the arms thin. It walks in nerves. I heard all of these. I don't take any of these methods for all that fear."

P24 (Age: 35, Years of husband's migration: 18 yr, Visited last year: 5 times, Stayed each time {average}: 4 days)

4.4.5. Permanent methods

Women said that permanent methods like tubal ligation and vasectomy were available at government health facilities and these were usually free of cost. In addition, they knew that people who adopted these methods got money from the government hospital.

Women generally do not have positive views about these two permanent methods. Their views are related to such things as their younger age, the uncertainty of people's lives, and the fact that family sizes are smaller than in previous generations. Many women think that these two permanent methods were more for the older generation, when there was not the variety of family planning methods available now. There is one woman in the sample who took an herbal method to permanently prevent pregnancy, as she did not want any more children, however, still she did not consider doing tubal ligation. Many women raised the concern of what might happen if their children died and they could not get pregnant again. Some women also gave the example of such cases around their community who lost their children accidently and could not get pregnant anymore as the women had had tubal ligation.

Religious restrictions also strengthen this notion as one women said,

"From Islamic point of view I heard that their 'janaja' (funeral prayers) will not be approved. Everyone has to die. Though it is for birth control, however, I have to do that within my life philosophy. I can take pill, I can do withdrawal, I can buy condom for use, but doing a surgery! I do not like do surgery for birth control."

P24 (Age: 40, Years of husband's migration: 12 yr, Visited last year: 5 times, Stayed each time {average}: 10 days)

Like long-term methods, a permanent method is also discarded as an option because of the surgical process attached to it. Generally, community people have negative views about any surgical invasion. The fact that male doctor would see the body while doing surgery and the fact that other people in the community would know about their family planning method if one adopts this method also emerged as a major barrier for not considering this method. This woman said,

"…It's an operation. People do not know if you use pill or injection but everybody will know about your operation."

P7 (Age: 29, Years of husband's migration: 15 yr, Visited last year: 6 times, Stayed each time {average}: 7 days)

Community people also believe that such a procedure affects the health in the long run, making women and men weak and less productive. A woman said,

"They (who have done the ligation) said that they cannot do heavy works and cannot take heat (while cooking), they feel very tense."

P3 (Age: 34, Years of husband's migration: 16 yr, Visited last year: 2 times, Stayed each time {average}: 7days)

Interestingly, it was also highlighted that even though a woman could take this permanent method, a man should not have a vasectomy since there is this widespread belief that such surgery makes a man weak and consequently affects both the family economy and conjugal life as one women said,

"If anyone do that he would lost his strength which hamper conjugal life as he wouldn't have the strength to do that (sex)."

P20 (Age: 18, Years of husband's migration: 2y, Visited last year: 3 times, Stayed each time {average}: 30 days)

In our sample, at least eight informants/couples reached the desired number of children, however still they did not want to consider the permanent method for themselves due to the uncertainty of the children's survival. However, they also think that if somebody had five or six children, they could use a permanent method. This woman said,

"I will not take further child. If I do the operation, I will never be pregnant in my life time. Who knows about the future which is totally depending on Allah? It may happen that all of my children would die. Anybody can die any time."

P23 (Age: 28, Years of husband's migration: 13 yr, Visited last year: 3 times, Stayed each time {average}: 5 days)

One woman considered tubal ligation appropriate for her since she had reached the desired number of children, however she could not take it due to her religious belief. She thought that those who were not a follower of religious rules could adopt this method as she said,

"I like the method (tubal ligation) but I am not taking it as it is a sin. Not all people take it (abortion) as a sin like me. So they can take the method if they wish and don't think it as a sin because not all people obey God's rule. It's an individual choice whether she abort pregnancy or not."

P14 (Age: 31, Years of husband's migration: 5 yr, Visited last year: 5 times, Stayed each time {average}: 5 days)

4.4.6. Traditional methods

Table 2 shows that a few women/couple used traditional methods, namely withdrawal and safe period,[1] a fertility awareness-based method. While many women know about these methods, they were not interested to use those since the couples find it very risky. This is why traditional methods were often used simultaneously with another method namely pill and condom, as a stopgap measure when women experienced side effects from use of other FP methods, or when the method was not readily available at home.

While women described withdrawal easily as *"men throwing his thing outside"*, the data suggest that women described the safe period in her cycle different ways: some said it is the first and last 10 days of menstruation while others say that 15 days after menstruation is dangerous period. One woman said,

> *"…I heard that if sexual intercourse occurred after one week of ending menstruation then there is a chance of getting pregnant. This is the fertile period. If sexual intercourse occurs before one week of starting menstruation then nothing will happen as it is not the fertile period for women."*
>
> P9 (Age: 24, Years of husband's migration: 8 yr, Visited last year: 10 times, Stayed each time {average}: 7days)

Another women said,

> *"There is 3 parts in a 1 month each having days. You will not get pregnant at the initial first 10 days. The middle 10 day is danger period, you will be pregnant if you do not use any method during that time. And the last 10 days, it is ok if you do not take pill during that time."*
>
> P23 (Age: 28, Years of husband's migration: 13 yr, Visited last year: 3 times, Stayed each time {average}: 5 days)

Based on these issues related to accessibility, availability, and appropriateness of a particular method, women's health issues, social concerns, and contraceptive knowledge, experiences and perceptions influence women with migrant husbands to make contraceptive choices, or to switch from one method to another over their reproductive lives. Women's experiences can be quite complex, as was expressed by a woman who said,

> *"What can I do now? I have to take a method, that's why I switched from one method to another."*
>
> P16 (Age: 39, Years of husband's migration: 30 yr, Visited last year: 7 times, Stayed each time {average}: 7 days)

[1] Fertility based method in which women identify the point of their cycle in which the risk of pregnancy is highest and take some action to avoid pregnancy, such as avoiding sex (periodic abstinence), using condom or withdrawal

Another woman, echoing the same frustration said,

> *"Males usually don't use anything and they don't have to insert anything into them...All methods are for female and males are free from these."*
>
> P12 (Age: 29, Years of husband's migration: 20 yr, Visited last year: 10 times, Stayed each time {average}: 10 days)

4.5. Perceptions of Risk of Getting Pregnant

Data suggested that most of the couples were very concerned about getting pregnant accidently and, therefore, they tried to strategize their family planning use as best as they could. There were couples who ensured that the method was available at home when the husband returned for visits. This woman said,

> *"If it is not available at home and he comes, and if we have intercourse, then I will be pregnant. So I keep this (pill) at home."*
>
> P16 (Age: 39, Years of husband's migration: 30 yr, Visited last year: 7 times, Stayed each time {average}: 7 days)

Another woman said,

> *"Otherwise I may have problem, I would be pregnant. But I do not want to take child. So to avoid the issue which I do not want to take, I told him to bring the method. If I told him over phone then he brought otherwise he brought it from the village sometime he missed to bring, if he strait come by launch he cannot buy, or he may not get shop on his way, then I took pill which I had at home, next day he buys from bazaar."*
>
> P23 (Age: 28, Years of husband's migration: 13 yr, Visited last year: 3 times, Stayed each time {average}: 5 days)

Another woman said,

> *"He came on last Sunday and went away this Sunday. He came to appear an exam. I didn't leave pill taking after he left. He also said not to leave. Sister-in-law also said, 'he will come again so you shouldn't leave taking pill. For a single mistake you will be pregnant.'…"*
>
> P20 (Age: 18, Years of husband's migration: 2 yr, Visited last year: 3 times, Stayed each time {average}: 30 days)

There were many other strategies that couples adopted. For instance, they switched to another method, particularly condoms and withdrawal, when the women were facing side effects due to using other methods. They often did not totally rely on withdrawal and condoms, which they knew could be ineffective sometimes. Husbands reminded their wives to take the pill during times when they lived together or reminded them the next day if the wife forgot to take pill previous night. Husbands adopted withdrawal even when their wives assured about safe period and many more strategies they themselves came up with and followed. This woman said,

> *"He (husband) stayed 7 days at home, so I took seven pills. After his leaving I didn't take any pill. He got angry and said, "You should take all the pills as I spent here, there is no problem if you take all the pills, more over it is good."*
>
> P23 (Age: 28, Years of husband's migration: 30 yr, Visited last year: 3 times, Stayed each time {average}: 5 days)

Data also suggested that some couples used condoms or other methods or consulted with a physician to take a method during the post-partum amenorrhea period so that unintended pregnancy did not take place. Women informed that they learned from the older neighboring women that pregnancy could take place even during this time and hence this action.

Data also suggested that many women continued a new sheet of pill without giving any pause for menstruation when red pills were supposed to be taken. This they did when the husbands visit was approaching and the wives' menstruation cycle was approaching. Women said that they learned from other community people that pregnancy could take place even during when the women was menstruating and hence such initiatives. Couples also strategized husband's visits based on her menstruation dates and safe period and took methods when they were unable to do that. This woman said,

> *"It might cause pregnancy if sexual intercourse occurs during menstruation. That's why when my husband stay during that time, I never take red ones and start using white pills of another sheet. You can't assume the desire of husband. Excessive bleeding exist 4 days during menstruation then it decrease gradually. All in all, you need to wait 8-10 days, but when my husband stays at home during this time it couldn't possible to restrict him doing sex hence I don't take red ones at times when my husband stay around me."*
>
> P5 (Age: 24, Years of husband's migration: 10 yr, Visited last year: 3 times, Stayed each time {average}: 30 days)

Another woman said,

> *"My husband is at home since 2 months. I didn't take the red one. When my white pills finished I started another sheet without taking red pills. It is said on the packet that menstruation occur when you finish your white one but sometimes menstruation occur 2 or 3 days later. So, there is a chance of getting pregnant. That's why I didn't take the red one and started a new sheet of pill"*
>
> P15 (Age: 29, Years of husband's migration: 14 yr, Visited last year: 12 times, Stayed each time {average}: 7 days)

The entire discussion above also revealed that women continued to take different types of methods and switched from one to another due to different types of side effects perceiving the risk of getting pregnant accidently. Such cautiousness occurred often after an unintended pregnancy was experienced. Data also revealed one couple who were totally very ignorant and did not have adequate perceptions of risk of getting pregnant.

4.6. Issues Influencing Couple's Decision Regarding Family Planning Method

The previous sections have explored how decisions and discussions between spouses about use of contraceptive methods occur in the context of the husband's visits home. This section will explain how the decision whether to use a family planning method, when to use a method, and what method to use, fits into the broader social context of the migrant husband situation. Data suggest that decisions and discussions surrounding family planning were more influenced by general social norms and the views of other women than by the husband's migration pattern. These discussions include such issues as family expectations that a newly married woman will have a child right away, and that she will not use any contraceptive methods before having a child.

Most women, along with those who started using family planning after the first child, said that they always decided what method to use and when to use it; they just informed their husbands regarding their decision and the husbands agreed. Once the decision was made, husbands always supported the wives in terms of bringing the methods with them on their way to home and some of them decided to use condom and withdrawal occasionally or frequently when the wives faced severe problems for taking pills or visited when the wives assured that it would be her safe period during the time they would meet.

There were a couple of husbands who consulted with physicians regarding the side effects their wives were facing and took active role in changing the methods. This woman said,

> *"Doctor asked me whether I was taking birth control pill or not. I said yes. Doctor didn't say anything like you shouldn't take pill or it will not work etc. but I was afraid to take. Wouldn't it normal to have fear as you saw there are many women who need to go for pregnancy termination destroy pregnancy (baccha nosto). Why they have to go as for their negligence. If you are bit careful you need not to take that hassle. That's why I was not interested to take pill anymore."*
>
> P21 (Age: 40, Years of husband's migration: 12 yr, Visited last year: 5 times, Stayed each time {average}: 10 days)

On the other hand, some women also said that there were instances over their reproductive lives when they started using methods without informing the husbands fearing that they would restrict it and informed them later. In most cases, these husbands also did not place restrictions or make any chaos when they learned afterward about this contraceptive use. This woman said,

> *"I didn't seek permission, I informed him later. He didn't say anything. Actually he always ready to maintain safety (to do something to avoid pregnancy), as he said it will be problematic to take child without any birth spacing. He didn't like to take a child then. It is good to take another child after grown up of elder child."*
>
> P15 (Age: 29, Years of husband's migration: 14 yr, Visited last year: 12 times, Stayed each time {average}: 7 days)

Some women also said that, like them, their husbands were also not interested in having a child immediately and reminded them to take pills regularly and made them cautious to not get pregnant accidently. Many couples communicated over the phone before the husbands' visit to figure out if methods were available at home or not or if husbands needed to bring the methods with them. This woman said,

"It was our decision to take child then as we discussed that I might not be pregnant if use pill for long time. It was our discussion that as it is contraception it may cause of infertility, if I wouldn't have child! We also knew others experience about infertility due to taking pill. Then we decided to take child and we discussed that I would take pill later after having a child. Then I stopped taking pill"

P21 (Age: 40, Years of husband's migration: 12 yr, Visited last year: 5 times, Stayed each time {average}: 10 days)

However, there were instances where husbands were not at all involved and it was the wives who took the initiative regarding use of a family planning method. This woman said,

"I always took pill, one day I just told him to use condom, he said, 'no, how could you tell that, I will never use that thing. He said, fie! For shame I will not use that.'"

P23 (Age: 29, Years of husband's migration: 13 yr, Visited last year: 3 times, Stayed each time {average}: 5 days)

In general, the data suggested that even if there were restrictions from some of the husbands just after the marriage, most couples took the decision together regarding use of family planning over the time considering the health factors of women, family's economic condition, number of desired children, and spacing between children. Almost half of the women suggested that they planned for the next pregnancy or planned not to have any more children together. There were also a couple of husbands who did not want to have any more children even after the first one who was a girl. This woman said,

"My daughter was born 6 years after my son. Mostly people want two children. My husband told that he is fine with one child but later I convinced him for second child (the daughter)."

P15 (Age: 29, Years of husband's migration: 14 yr, Visited last year: 12 times, Stayed each time {average}: 7 days)

One woman said that her husband would be retiring soon and living in the village regularly; they would decide to use an appropriate method based on the context.

4.7. Experiences with Intended and Unintended Pregnancies

Based on pregnancy experience, the informants in the sample were divided into three types: ten women did not have any unplanned pregnancies; four women had unplanned pregnancies that were terminated; and eleven women had unplanned pregnancies that were not terminated. The data suggests no association between age of the women or duration of the marriage and the experiences of having or not having any unintended pregnancies.

There is widespread belief that menstrual regulation (MR)/abortion is a sin, although a number of women terminated or tried to terminate their pregnancies. As this woman said,

"By aborting, a life was killed. So it is best to let the child come. The life who wants to come, killing it is not good"

P21 (Age: 40, Years of husband's migration: 12 yr, Visited last year: 5 times, Stayed each time {average}: 10 days)

Another woman said,

> *"It is a sin to destroy the creature of Allah."*
>
> P15 (Age: 29, Years of husband's migration: 14 yr, Visited last year: 12 times, Stayed each time {average}: 7 days)

Women said that MR should be done secretly because community people do not take it well due to the fact that killing a life is considered sin. Along with religious restriction, women consider MR harmful for various reasons. One woman said that the doctor did not want to terminate her pregnancy because it was her first pregnancy. A few women said that the first child should never be terminated because it could make the women infertile for the rest of the life. This was a concern of some of the women in the sample who did not terminate their pregnancies even though it was unplanned. This woman said,

> *"I heard it from others that if you put off first fruit then you will not get any fruit in future. If you keep the first fruit you will get fruit next time also."*
>
> P20 (Age: 18, Years of husband's migration: 2 yr, Visited last year: 3 times, Stayed each time {average}: 30 days)

Another woman said,

> *"It was my first child. I was free that time, I had no study, I stayed always at home, so I would take care of the child, that's why I took the child…though it was not planned, but we keep it as it came."*
>
> P19 (Age: 2, Years of husband's migration: 8 yr, Visited last year: 4 times, Stayed each time {average}: 2 days)

Many women mentioned implications on women's health due to carrying out the MR. They mentioned that considering this, MR was usually suggested to be carried out before 3 to 4 months. This woman said,

> *"I heard that it should be before 4 months of pregnancy. Otherwise it will be a matter of life risk (of mother)…A baby gets her/his proper shape in 5 months of pregnancy. It is a matter of risk to terminate pregnancy after that time; it's a kind of delivery. Woman can face anemia or she can die. Most of the women die in this condition. Moreover it is a sin to abort a child especially on that time."*
>
> P15 (Age: 29, Years of husband's migration: 14 yr, Visited last year: 12 times, Stayed each time {average}: 7 days)

Another woman in this regard, while supposedly talking about the vacuum aspiration method in a later gestational period, said,

> *"It becomes hard as the child becomes big. It is attached inside of mother's womb. I do not know how they pull out it with a machine from inside. But if it is done by early stage it is not that much painful. A machine need to insert thorough the private place and they pull it out. It causes lot of bleeding and pain for the mother. But if you do this by 2/1 month it is not that much painful."*

P23 (Age: 28, Years of husband's migration: 13 yr, Visited last year: 3 times, Stayed each time {average}: 5 days)

For all these reasons, most women tried to plan their pregnancies, however only 10 women were able to do this until the time of the interview. As mentioned above, the age of these women and their duration of marriage varied; their age range was mostly from 18 to 29, including one 40-year-old; the duration of marriage ranged from 1.5 to 16 years. These women said that they were extra careful to protect against a mistimed pregnancy so they could achieve their goal. One such woman said,

"…Wouldn't it be normal to have fear as you saw there are many women who need to go for destroy pregnancy (baccha nosto). This they had to do because of their negligence. If you are bit careful you need not to take that hassle..."

P21 (Age: 40, Years of husband's migration: 12 yr, Visited last year: 5 times, Stayed each time {average}: 10 days)

Interestingly, some of these women used the pill only during the husband's visits because they thought it appropriate, as described earlier, and did not think they risked getting pregnant.

More than half of the women in the sample had unplanned pregnancies (13 of 23). Data suggested that most of these women/couples had tried to strategize their method use considering the husband's pattern of visits, women's health, family's economic conditions, the couple's desire to complete education, or the desired number of children with spacing to prevent unplanned pregnancies. However, in many cases they failed. Many women said that they did not know the reasons they became pregnant, especially when they were using a contraceptive method. This woman said,

"Actually, though I was using condom, I conceived. I don't know why it happened."

P9 (Age: 24, Years of husband's migration: 8 yr, Visited last year: 10 times, Stayed each time {average}: 7 days)

However, some women also mentioned that they think they forgot to take pill during the short stay of their husbands or the fact that the safe period that they calculated was just not effective. Women who were using pill only during husband's returns said this, and did not attribute pregnancy to the way that they were taking the pill intermittently. They thought they were protected. Incidentally, both types of failure (missing pills and taking part of a cycle of pills) are both "use failure."

Some woman said that they got pregnant during amenorrhea ("mura pet") when they were using withdrawal (which did not work). Some mentioned lack of available methods (injection) at the facility. Others missed the time their injection was due. Finally, there were cases of method failure because women used herbal medicines. One woman who got pregnant because injection was not available at the facility said,

"…they (community women) told me that since the hospital is no longer providing any pills or injections, I will have to do the surgery if I want to control the pregnancy…they (the HWs) took many people (women) in the hospital and did the operation (ligation). I did not go there as I was scared"

P3 (Age: 34, Years of husband's migration: 16 yr, Visited last year: 2 times, Stayed each time {average}: 7 days)

4.8. Experience with Termination of Pregnancy

Four women in the sample had pregnancies terminated. Reasons for pregnancy termination included the following: 1) couples wanted to delay having children just after marriage, 2) couples wanted a longer time between two children, 3) women's and children's health/age was of concern, and 5) there was concern about the family's economic situation. In most cases, couples decided jointly on going ahead with the termination, although, in most of the cases, their decision was against the will of other family members. This woman said,

> *"My husband agreed with the decision but everyone advised me to keep it because none of them had children in the family. I did it because of my baby's health and my health. At some point my husband was also puzzled about what to do. Then I took the final decision and he agreed."*
>
> P9 (Age: 24, Years of husband's migration: 8 yr, Visited last year: 10 times, Stayed each time {average}: 7 days)

This woman said further,

> *"Of course Allah will (punish me)...But, we need to think about feeding, educating and rearing the child and thinking that we had to terminate the pregnancy. We decide that we will not take any further baby. Two children are enough for us...."*
>
> P9 (Age: 24, Years of husband's migration: 8 yr, Visited last year: 10 times, Stayed each time {average}: 7 days)

Another woman said,

> *"She (mother-in-law) was very much angry and beat me with a broom. I was sitting outside without taking food whole day. But we did the MR."*
>
> P15 (Age: 29, Years of husband's migration: 14 yr, Visited last year: 12 times, Stayed each time {average}: 7 days)

Most women had their MR carried out by a village doctor or traditional provider; some had the services of a skilled provider.

The remaining nine women had unintended pregnancies—some more than one. None of the remaining women terminated any of their pregnancies. Reasons for not going for the MR included the following: 1) religious restrictions, 2) family members' restrictions, 3) assumed painful procedures, and 4) negative consequences for health including infertility. One woman said,

> *"Destroying a life is a great sin. We can't create human so how we think about destroying it. I don't like it. A child is like a flower garden for women. I can also die in time of killing my baby at womb."*
>
> P7 (Age: 29, Years of husband's migration: 15 yr, Visited last year: 12 times, Stayed each time {average}: 7 days)

In few cases, the woman wanted the MR but the husband did not, so the women had to continue the pregnancy against their will. One woman said,

> *"I decided to do pregnancy termination. I didn't have desire to take any more children. But my husband didn't agree. Elders also said to keep my pregnancy. My 2 months running at that time. My husband didn't give me the permission of pregnancy termination. I went to Doctor but Doctor said he couldn't do anything without husband's permission."*
>
> P24 (Age: 35, Years of husband's migration: 18 yr, Visited last year: 5 times, Stayed each time {average}: 4 days)

All these women knew about the sources where MR could be done and most of their sources of information were from neighboring and relative women who carried out MR and from their own experiences. They mentioned about traditional providers/herbalist, private clinics, health workers of government hospital, Thana health complex, and pharmacy or village doctors where tablets were available to terminate pregnancy. Some women said that doing MR with traditional providers could be very harmful for the woman and the woman often could die doing MR with them. Women said that often these traditional providers carry out the MR beyond 3 to 4 months, which can have negative consequences for women's health. A number of women talked about tablets available at the pharmacies and often women appear to have a clear idea about misoprostol. One woman who had a MR with herbal medicines and with misoprostol said,

> *"…I told him (medicine shop keeper) that salsa (an herbal medicine) is not enough for me as it will work only if it were simply irregular menstruation. But if it is pregnancy it will not work. Then you need to take tablet. Then I need to eat two tablets and insert three tablets in to menstruation canal, and it will be clear by night."*
>
> P23 (Age: 28, Years of husband's migration: 13 yr, Visited last year: 3 times, Stayed each time {average}: 5 days)

Women also said that sometimes couples went out of their village to carry out the MR so that community people could not know about it.

5. Discussion

5.1. Demographic Factors

On average, the couples were stable (i.e., married for several years), with a considerable age gap between the spouses, and women were married off earlier than the legal marriage age in the country. These statistics indicate, besides the general patriarchal structure of the Bangladeshi society, there might have existed a male domination in terms of various familial decision making, including the family size, method use/non-use, and other related issues (Zakia Hossain 1998; Islam, Padmadas, and Smith 2006; Story and Burgard 2012). The fact that most of the women remained with their in-laws might have further diminished their autonomous decision-making capacity (Bloom, Wypij, and Gupta 2001, p. 69). However, the study results suggest otherwise. Despite this demographic context that appears disempowering for the women, most of the decisions were in fact mutual, with very little coercion in arriving at those decisions (Becker, Fonseca-Becker, and Schenck 2006).

5.2. Migration of Husbands

Husbands' visit to home have been anything but a surprise or something that the women needed to be accustomed to since most of them married into it. The migratory pattern indicates a regular interval and several days of stay with the spouses. As almost a rule, it was husbands visiting their wives, and not the other way around.

Among the ones whose husbands migrated for work after marriage, some tried to live with their husbands, but soon abandoned the idea.

5.3. Mobile Phones

Access to mobile phones seems to have had an undeniable impact on husbands visiting their spouses and the planning related to their contraception usage. It seems to have made life easier and less worrisome, since it is now possible to plan ahead of the visits, unlike the times when there was no such avenue opened to them. It is not a guaranteed way, but it surely reduces the chances for any unwanted events.

5.4. Contraception and Usage Patterns

Generally speaking, lack of knowledge with regard to contraception use, specific ways that each of the methods work, and when and why one should use a specific one is at the very heart of unintended pregnancies (Chen, Liu, and Xie 2010; Tsui, McDonald-Mosley, and Burke 2010; Frost, Lindberg, and Finer 2012; Haque et al. 2015). The sort of regularity that is required in administering a specific method (namely, pills) to successfully avoid unintended pregnancies is unfortunately absent. With migration, this fact has become further pronounced, since women tend to become even more erratic in their contraceptive use. They have good knowledge (by traditional measures), but use the pill the wrong way anyway. They use it wrong because they misunderstand how the pill works with regard to the protection it offers.

Over time, couples try out different methods of contraception that are not linked to migration of their husbands, but mostly because of what they deem as suitable to their health. Generally speaking, pills are the preferred method, and younger couples are trying out condoms more frequently than the older couples, which is consistent with previous studies (Daniel, Masilamani, and Rahman 2008; Kershaw et al. 2012; Chandra-Mouli et al. 2014; Dai et al. 2015) This is an avenue that needs to be explored

further, since this indicates more receptiveness among the younger generation of couples, men specifically, to various family planning messages that they might be exposed to.

5.5. Pills

Incorrect information can create an economic burden on the women in our sample. For instance, some women thought that it is not healthy to continue with one specific brand of pills over time and that they need to change brands periodically; they also circulated this notion to other women. This idea can and did lead women to consider buying more expensive brands, when in fact the cheaper brand is just as effective and poses no more risk than the more expensive brand.

Husbands' migration does not put any additional barrier in terms of collection of contraceptive methods, in this case, pills, since women inform them beforehand over mobile phone that they need to bring home the pills. However, this pattern clearly suggests how misinformed these couples are with regard to how to use pills (i.e. using pills only when one is planning on having sex is not the correct way). Interestingly, when asked about the rules of taking the pills, women were able to relay it properly, but in practice they only took the pills whenever their husbands visited them. It should be mentioned here that providers are not explaining, as they should, the rules and risks of not following the rules correctly of how to take the pills. In addition, local health workers are also contributing in spreading the incorrect messages (Koenig, Hossain, and Whittaker 1997; Dehlendorf et al. 2010; Mahmud et al. 2015). When coupled with the experiences of other women with migrating husbands, certain incorrect ideas become standard practice.

Problems related to the use of pills contribute heavily to the discontinuation of pills when husbands are not around (Khan 2003; Bradley, Schwandt, and Khan, 2009; Singh, Roy, and Singh 2010; Azmat et al. 2012). Side effects (e.g. headaches, body ache, burning sensation, dizziness, vomiting, etc.) and the need to consistently remember to take pills every day are the primary reasons why women have devised their own rules as detailed above. Due to the complaints related to experiencing side effects from pills, women also switch from one brand of pills to another, and also to other methods of contraception. It is also to be noted that their husbands' absence also provided a kind of respite from the burden of taking pills regularly.

However, some women voiced a long standing concern of having pills delivered at their doorstep. Research has shown that not having the pill delivered at home in fact worked as a positive factor toward empowerment while some of the traditional barriers, i.e. feeling shy to go out in the market to buy contraceptives, still exist in the society. Men, wanting children, also try to impose their choices on women and become unsupportive of their choices, which some women think they can handle if the methods were delivered at their homes (Kamal 2000; Arends-Kuenning 2002; Kamal and Islam 2010).

The preference for pills for the couples with migrating husbands was deemed appropriate since most women did not see the point of continuing on with a method (longer term methods especially) when their husbands were not around. Therefore, they chose pills, which, according to them, they could only take when their husbands were around.

5.6. Injections

Injections are not preferred because it is a problem for the women to visit a facility for it and also it is troublesome for them to remember the correct dates for the next dose. Unavailability of injections at the facilities (Seiber and Bertrand 2002; Laskar et al. 2006; Gubhaju 2009; Chandra-Mouli et al. 2014) is also a deterrent for them. Several women also perceived that health workers want them to

switch to long-acting and permanent contraceptives and that is why health workers said that injections were not in stock in the health facility. These perceptions work as a deterrent for the women to visit the facilities.

In addition to the above, there is also a perceived belief that prolonged use of injections may cause infertility (Campbell, Sahin-Hodoglugil, and Potts 2006; MacDonald et al. 2013). This is why younger couples do not want to avail it and only consider when they have a couple of kids. Moreover, women also believe that bleeding, waist pain, or excessive weight gain, etc. are related to the use of injections. Not menstruating for months on end is also a concern among the women that works as a negative factor in terms of choosing injections as a method for themselves.

As mentioned above, couples with migrating husbands did not find injections to be appropriate since they saw very little point in continuing on with a method when their husbands were not with them. However, a minority of women thought it was actually a better method since then they didn't have to worry about the sudden visits of their husbands.

5.7. Condoms

Several women think that condoms should be the most appropriate choice for couples with migrating husbands since the visits are sporadic and it relieves them of the pressure to continue on with any particular method. However, a plethora of perceptions end up becoming a barrier in terms of using them: many think it is not really as effective as other methods; many think it could be a health hazard it the condom breaks and a broken piece is left inside of them; and condoms can leak and defeat the very purpose of its usage.

Women know about sexually transmitted diseases and that some of that can be prevented through the use of condoms. However, none of the couples using condoms used it in order to protect themselves.

5.8. Long-term and Permanent Methods

To put it generally, longer-term methods like Copper-T and Implants were deemed as invasive and women appeared fearful of it (Sherris and Perkin 1989; Schein 1999; Bradley et al. 2009; Azmat et al. 2012). Though some of them could see the positive aspects of it helping them provide the peace of mind that they seek, it simply does not outweigh the fear attached to it. Only two of the entire sample had ever tried implants, but they also had them removed, because they experienced several side effects that they attributed directly to the method.

Like the longer-term methods, permanent methods were also disregarded primarily due to its invasive procedures. Even the couples those who appeared certain in their choices to not have any more babies, didn't want to consider permanent methods. Besides it being invasive, informants also talked about how they would be ridiculed and talked about in the society if they went through a surgical process in order to stop having babies permanently. Social pressure, as one would expect, determines a lot of our choices, though they may be personal and/or individual ones.

The gender dimension is interesting too with regard to adopting permanent methods (Khan and Rahman 1997; Kamal 2000; Becker, Fonseca-Becker, and Schenck-Yglesias 2006). Women believe that men should not have vasectomies since it can have debilitating effect on their performance in sexual relations, i.e. that they would "lose their power."

5.9. Traditional Methods

Women appeared apprehensive with regard to "traditional methods," which basically translated into withdrawal and "safe-period". They rightly believe these methods to be risky and not adequately protective. Their knowledge with regard to what is a "safe period" demonstrated that they were quite confused and hardly anyone could describe it with confidence. Most of their ideas were based on hearsay. However, they were themselves aware of it and tried to combine these methods with other methods, like that of pills and condoms.

5.10. What is Risky in Terms of Getting Pregnant?

Discussion on various methods reveals that women, and also men, go through lengths in order to plan their reproductive lives. If they do not want to get pregnant, they strategize their spouse's visit accordingly. However, switching methods, combining more than one method, adopting a new method or a new way, etc. may all in fact contribute in becoming pregnant since this "mix-and-match" and strategic behaviors might contribute to rendering the method/s ineffective. Lack of correct information with regard to method-specific sexual behavior might have contributed in unintended pregnancies in many women's lives and have burdened them further.

5.11. Decision-making with Regard to Family Planning

The study sample suggests that the decision-making process has been generally mutual. Meaning, in most of the cases both the woman and the man in a conjugal relationship contributed in deciding what the family planning method of choice would be, would there be a method at all, and things along that line. In fact, it was mostly women who decided and then suggested it to their husband, who consequently agreed to. Even the decisions on how many children and when to have them were decided on mutually. This is not to suggest that there is no sign of men imposing their choices on women, but the fact remains, that the evidence of such imposition were few and far between.

5.12. Intended and Unintended Pregnancies and Termination

Most, if not all, women tried to plan their pregnancies, hence their family size and timing of having a child. However, some succeeded and some didn't. Over half of the informants experienced unintended pregnancies. Among these, a minority went for MR. A very negative notion was voiced with regard to their perception of MR that was mostly related to religious injunctions against it (Khan et al. 2016). Health concerns were also talked about in the course. It was clear from their perceptions that they believe planning one's family (i.e. using a contraceptive method) is far better than having an MR.

Despite having a negative notion about MR, all of the women who had unintended pregnancies knew about MR, knew where to have it done (be it with an unskilled or skilled provider), and that it was better to have it done sooner rather than later. Among the women those who went through the procedure, it wasn't always an easy decision, and if all of the cases, the couple had to go against the relatives. The society, as one would suspect, is still far from being accepting of the procedure. However, women should pragmatic considerations in going through with their decisions to have MR—they considered if they had the resources to raise a child at that point and if the woman was in a healthy state of being to carry a child to term.

6. Conclusions

In conclusion, women's disempowered state of being seems to be in a positive transitional phase right now. In this situation, family planning education can make further inroads and involve men, positively, in a greater capacity.

Migration puts a challenge for the women to plan their family planning use. It definitely alters it and makes women adopt creative means of contraceptive use. However, being creative is one thing, and being methodologically correct is another, and it is the latter that is more important when it comes to averting a pregnancy.

Use of mobile phones has become a blessing for the couples whose husbands have left home for work. It has provided the avenue to plan their stays together, procure family planning methods when needed, and reduce risky behaviors in terms of coital practices. Programmatically, there needs to be more thought given to these new advancements in technology and make it work for couples who may now be prepared to avail such interventions.

Women definitely want to avoid getting pregnant, though often they were not prepared for it or lack knowledge. Therefore, planning their coital behavior is at the very heart of their family planning use. However, despite their intention and worries related to it, they may not be doing the right when it comes to using a particular family planning method.

Women may not be getting appropriate information from the field-level health workers that address their needs. There was also a lack of trust in health workers at facilities when the method that the women wanted to use was unavailable and other methods were promoted instead. This lack of trust created a disincentive to visit via health facilities. Health workers' knowledge about methods needs to be assessed and correction, and communication with clients needs to be improved.

Women lack family planning education, especially with regard to contraceptive pills and how they should be taken and, therefore, this must be made a policy priority. It is unfortunate that women, despite their intentions to limit their family size, are still facing unintended pregnancies, which are rendering all their efforts in planning fruitless. Education on all the other family planning methods, all the choices available to them, and suggestions of what might be a good one to adopt must be made clear to women as well, since not all women would choose the pill. Women-centered facilities should also be considered since many women avoid going to facilities

Along with education, women also need to be made aware about the possible side effects of each one of the methods, and proper ways of dealing with them without jeopardizing their family planning. Many women also harbor incorrect ideas about using pills and injections for a prolonged time. Also, there are misconceptions on what is "safe period." That should be addressed. These should be highlighted within their educational package.

Men seem to have become more and more involved in the familial matters with regard to family planning method choices, general birth control issues, and so on. This is a ripe time to get them involved further. The younger generation seems more receptive, which is a huge window of opportunity.

References

Arends-Kuenning, M. 2002. “Reconsidering the Doorstep-delivery System in the Bangladesh Family Planning Program.” *Studies in Family Planning* 33 (1):87-102.

Azmat, S. K., Shaikh, B. T., Hameed, W., Bilgrami, M., Mustafa, G., Ali, M., Ishaque, M., Hussain, W. and Ahmed, A. 2012. “Rates of IUCD Discontinuation and Its Associated Factors among the Clients of a Social Franchising Network in Pakistan.” *BMC Women’s Health* 12 (1):1–8. doi: 10.1186/1472-6874-12-8.

Ban, B., Karki, S., Shrestha, A., and Hodgins, S. 2012. “Spousal Separation and Interpretation of Contraceptive Use and Unmet Need in Rural Nepal.” *International Perspectives on Sexual and Reproductive Health* 38 (1):43-47.

Becker, S., Fonseca-Becker, F., and Schenck-Yglesias, C. 2006. “Husbands’ and Wives’ Reports of Women’s Decision-making Power in Western Guatemala and Their Effects on Preventive Health Behaviors.” *Social Science & Medicine* 62 (9):2313-2326.
doi: http://dx.doi.org/10.1016/j.socscimed.2005.10.006.

Bloom, S. S., Wypij, D., and Das Gupta, M. 2001. “Dimensions of Women’s Autonomy and the Influence on Maternal Health Care Utilization in a North Indian City.” *Demography* 38 (1):67-78. doi: 10.1353/dem.2001.0001

Bradley, S. E., Schwandt, H., and Khan, S. 2009. *Levels, Trends, and Reasons for Contraceptive Discontinuation*. DHS Analytical Studies No. 20. Rockville, Maryland, USA: ICF International.

Campbell, M., Sahin-Hodoglugil, N. N., and Potts, M. 2006. “Barriers to Fertility Regulation: A Review of the Literature.” *Studies in Family Planning* 37 (2):87-98.

Chandra-Mouli, V., McCarraher, D. R., Phillips, S. J., Williamson, N. E., and Hainsworth, G. 2014. “Contraception for Adolescents in Low and Middle Income Countries: Needs, Barriers, and Access.” *Reproductive Health* 11(1):1.

Chen, J., Liu, H., and Xie, Z. 2010. “Effects of Rural-Urban Return Migration on Women’s Family Planning and Reproductive Health Attitudes and Behavior in Rural China.” *Studies in Family Planning* 41(1):31-44.

Dai, W., Gao, J., Gong, J., Xia, X., Yang, H., Shen, Y., Gu, J., Wang, T., Liu, Y., Zhou, J., Shen, Z., Zhu, Z., and Pan, Z. 2015. “Sexual Behavior of Migrant Workers in Shanghai, China.” *BMC Public Health* 15 (1):1.

Daniel, E. E., Masilamani, R., and Rahman, M. 2008. “The Effect of Community-based Reproductive Health Communication Interventions on Contraceptive Use among Young Married Couples in Bihar, Indi” *International Family Planning Perspectives* 34 (4):189-197.

Dehlendorf, C., Levy, K., Ruskin, R., and Steinauer, J. 2010. “Health Care Providers’ Knowledge about Contraceptive Evidence: A Barrier to Quality Family Planning Care?” *Contraception* 81 (4):292-298. doi: http://dx.doi.org/10.1016/j.contraception.2009.11.006.

Frost, J. J., Lindberg, L. D., and Finer, L. B. 2012. “Young Adults’ Contraceptive Knowledge, Norms and Attitudes: Associations with Risk of Unintended Pregnancy.” *Perspectives on Sexual and Reproductive Health* 44 (2):107-116.

Gubhaju, B. 2009. “Barriers to Sustained Use of Contraception in Nepal: Quality of Care, Socioeconomic Status, and Method-related Factors.” *Biodemography and Social Biology* 55 (1):52-70.

Guest, G., Bunce, A., and Johnson, L. 2006. “How Many Interviews Are Enough? Experiments in Data Saturation and Variability.” *Field Methods* 18 (1):59-82.

Haque, M., Hossain, S., Ahmed, K. R., Sultana, T., Chowdhury, H. A., and Akter, J. 2015. “A Comparative Study on Knowledge about Reproductive Health among Urban and Rural Women of Bangladesh.” *Journal of Family & Reproductive Health* 9 (1):35.

Islam, M. A., Padmadas, S. S., and Smith, P. W. 2006. “Men’s Approval of Family Planning in Bangladesh.” *Journal of Biosocial Science* 38 (02):247-259.

Kamal, N. 2000. “The Influence of Husbands on Contraceptive Use by Bangladeshi Women.” *Health Policy and Planning* 15 (1):43-51.

Kamal, S. M., and Islam, M. A. 2010. “Contraceptive Use: Socioeconomic Correlates and Method Choices in Rural Bangladesh.” *Asia-Pacific Journal of Public Health* 22 (4):436-450.

Kershaw, T., Arnold, A., Gordon, D., Magriples, U., and Niccolai, L. 2012. “In the Heart or in the Head: Relationship and Cognitive Influences on Sexual Risk among Young Couples.” *AIDS and Behavior* 16 (6):1522-1531.

Khan, R., Khanom, A., Sultana, M., Akhter, R., Shelly, S. B., and Ali, N. A. 2016. *Menstrual Regulation: A Decision Tainted with Stigma, Pain, and Suffering – An Anthropological Study*. Dhaka, Bangladesh: EKN, Marie Stopes Bangladesh, and icddr,b.

Khan, M. A. 2003. “Factors Associated with Oral Contraceptive Discontinuation in Rural Bangladesh.” *Health Policy and Planning* 18 (1):101-108.

Khan, M. A., and Rahman, M. 1997. “Determinants of Contraceptive Method Choice in Rural Bangladesh.” *Asia Pacific Population Journal* 12:65-82.

Khanal, M. N., Shrestha, D. R., Panta, P. D., and Mehata, S. 2013. *Impact of Male Migration on Contraceptive Use, Unmet Need and Fertility in Nepal: Further Analysis of the 2011 Nepal Demographic and Health Survey*. DHS Further Analysis Reports No. 74. Calverton, Maryland, USA: Nepal Ministry of Health and Population, New ERA, and ICF International.

Koenig, M. A., Hossain, M. B., and Whittaker, M. 1997. “The Influence of Quality of Care upon Contraceptive Use in Rural Bangladesh.” *Studies in Family Planning* 28 (4):278-289. doi: 10.2307/2137859.

Laskar, M., Mahbub, M., Yokoyama, K., Inoue, M., and Harada, N. 2006. “Factors Associated with Contraceptive Practices of Married Women in Bangladesh with Respect to their Employment Status.” *The European Journal of Contraception & Reproductive Health Care* 11 (3):220-227.

MacDonald, L., Jones, L., Thomas, P., Thi Thu, L., FitzGerald, S., and Efroymson, D. 2013. “Promoting Male Involvement in Family Planning in Vietnam and India: HealthBridge Experience.” *Gender & Development* 21 (1):31-45.

Mahmud, I., Chowdhury, S., Siddiqi, B. A., Theobald, S., Ormel, H., Biswas, S., Rashid, S. F. 2015. “Exploring the Context in Which Different Close-to-community Sexual and Reproductive Health Service Providers Operate in Bangladesh: A Qualitative Study.” *Human Resources for Health* 13 (1):51.

Massey, D. S., and Mullan, B. P. 1984. “A Demonstration of the Effect of Seasonal Migration on Fertility.” *Demography* 21 (4):501-517. doi: 10.2307/2060912.

Morse, J. 1994. “Designing Funded Qualitative Research.” In *Handbook for Qualitative Research*, ed. N. Denzin and Y. Lincoln, 220-35. Thousand Oaks, CA: Sage.

National Institute of Population Research and Training (NIPORT), Mitra and Associates, and ICF International. 2013. *Bangladesh Demographic and Health Survey 2011*. Dhaka, Bangladesh and Calverton, Maryland, USA: NIPORT, Mitra and Associates, and ICF International.

Patton, M. 2002. *Qualitative Research and Evaluation Methods.* 3rd ed. Thousand Oaks, CA: Sage.

Schein, A. 1999. "Pregnancy Prevention Using Emergency Contraception: Efficacy, Attitudes, and Limitations to Use." *Journal of Pediatric and Adolescent Gynecology* 12 (1):3-9.

Seiber, E. E., and Bertrand, J. T. 2002. "Access as a Factor in Differential Contraceptive Use between Mayans and Ladinos in Guatemala" *Health Policy and Planning* 17 (2):167-177.

Siddiqui, T. 2005. "International Labour Migration from Bangladesh: A Decent Work Perspective." *Policy Integration Department Working Paper* (66).

Sherris, J., and Perkin, G. W. 1989. "Introducing New Contraceptive Technologies in Developing Countries." *Demographic and Programmatic Consequences of Contraceptive Innovations* 251-264: Springer.

Singh, K. K., Roy, T. K., and Singh, B. P. 2010. "Contraceptive Discontinuation and Switching Patterns in Bangladesh." *Genus* 66 (1):63-88.

Story, W. T., and Burgard, S. A. 2012. "Couples' Reports of Household Decision-making and the Utilization of Maternal Health Services in Bangladesh." *Social Science & Medicine* 75 (12):2403-2411.

Tsui, A. O., McDonald-Mosley, R., and Burke, A. E. 2010. "Family Planning and the Burden of Unintended Pregnancies." *Epidemiologic Reviews* 32:152-74. doi: 10.1093/epirev/mxq012

Zakia Hossain, S. 1998. "Decision Making, Use of Contraception, and Fertility in Bangladesh: A Path Analysis." *International Journal of Sociology and Social Policy* 18 (7/8):27-55.