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SUMMARY REPORT 'Traditional' Family Planning in Bangladesh



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SUMMARY REPORT

**'TRADITIONAL' FAMILY PLANNING
IN BANGLADESH**

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*A collaborative project of Population Council, Bangladesh,
the National Institute of Population Research and Training (NIPORT),
the MCH-FP Extension Project, Rural, ICDDR,B,
and Associates for Community and Population Research (ACPR),
with support from USAID, Dhaka*

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Preface

The background to this Project was a concern that Bangladesh relies heavily on a handful of contract research organizations to generate most of its population data, and in many cases to provide population policy guidance to the Government. A more desirable situation would be that the country has a number of stable research institutions with well trained researchers capable of conducting policy relevant research for the Government and others.

The objective of the Project then, has been to provide the opportunity to a group of less experienced researchers to gain experience by participating in a number of studies under the guidance of more experienced researchers. In addition to their involvement in every step of the research process, from study design and questionnaire development, through the fieldwork and data collection phase, to writing the final report, these researchers have received formal training in data collection, data analysis, presentation techniques, and other aspects of research from the hands of the senior members of the Project.

In addition to the above mentioned objective of building policy research capacity, a further objective was to make the studies relevant in their own right. For this reason all the studies were designed to focus on issues of current importance as the whole field of population research is evolving to include broader aspects of reproductive health. The titles of the five studies reflect this emphasis:

- (i) Opportunities for Integration of RTI/STD Services into FP-MCH Programs.
- (ii) Strengthening STD Services for Men in an Urban Clinic Based Program.
- (iii) Study of Adolescents: Dynamics of Perceptions, Attitudes, Knowledge, and Use of Reproductive Health Care.
- (iv) Traditional Family Planning in Bangladesh.
- (v) Increasing the Financial Sustainability of Family Planning Service Delivery in Bangladesh

The completion of these five studies from recruitment of the research staff through the initial design, to the production of the final study reports, has taken place over the past twelve to eighteen months. Needless to say this has been a period of intense activity, but we hope the readers will consider the products to be worthwhile.

While we believe this Project has contributed to the building of the research capacity of our team, there remains the issue of building research institutions for researchers to function in. We encourage the Government, the development partners, and our fellow researchers to continue to strive to achieve this important goal.

Karin Streatfield
Project Director.

Acknowledgements

This study was carried out by the Population Council under a USAID-funded project titled 'Strengthening Population Policy and Research Capacity in Bangladesh'. The project commenced in 1995 and will end in July 1997. This study was conducted with the National Institute of Population Research and Training (NIPORT), in collaboration with the MCH-FP Extension Project (Rural) of the International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B). The field study was carried out by Associates for Community and Population Research (ACPR).

The authors of this report wish to acknowledge the contributions made by a large number of people who worked on various aspects of the project. From the Population Council, Dr Sharif undertook valuable literature search work, Ms Unnati Rani Saha worked tirelessly investigating existing survey data, Dr Nazmul Huda and Ms Nahid Kamal contributed timely assistance with translating indepth interviews, and Dr Indrani Pieris did initial work on analysis of the in-depth interview information, at the same time assisting ACPR to manage the translation work. Throughout the project, administrative and support staff of the office ensured that operations proceeded smoothly, and special thanks are due to the contributions of Mr Dipak Shil and Mr Shahinul Islam. From NIPORT, Ms Mita helped with the preparation of data from previous surveys. Dr Indrani Haque from the MCH-FP Extension Project (Rural), ICDDR,B, did a professional job of selecting the samples for the pretest and field study.

The Director of the MCH-FP Extension Project (Rural), ICDDR,B, Professor Barkat-e-Khuda, generously extended every assistance that he could to the study. Similarly, the Executive Director of ACPR, Mrs Haidary Kamal, committed all the expertise of her organization to successful completion of the study.

From the office of ACPR, Mr Md. Nurul Islam, Ms Tamanna Tariq, Ms Quamrun Nahar, Ms Rabeya Khan, Ms Momena Begum and Ms Nargis Sultana processed the field data, Mr Md. Moniruddin did the data entry and Ms Rezina Sultana and Mr Abdur Rahim provided administrative support. Mr M.A. Zaman, Prof. M. Amanullah and Ms Zubaida Nasreen translated the in-depth interviews from Bangla to English. The scale of the work contributed by all these people can be appreciated from the fact that the translated in-depth interviews amounted to over 2.6 megabytes of text.

The core of the study is the field data, and those of us (Alan Gray, Jamil Chowdhury and Bruce Caldwell) who had the fortune to spend time at the field sites with the interview teams wish to record our special gratitude for the valuable insights which all of the interview team members contributed in regular discussion sessions which accompanied the work in the field. Many of the ideas presented in this volume arose out of the vigorous exchange of these discussion sessions, and can only be attributed to the survey team as a whole, not to any individual author of the report. Mr S.M. Salamat Ullah, Ms Sonali Sarker, Ms Zebun Nessa and Mr Pijush Kumar Bhattacharjee conducted the pretest interviews. For the main part of the study, Mr S.M. Salamat Ullah and Ms Zebun Nessa provided field supervision and quality control, and Mr Pijush Kumar Bhattacharjee, Mr Nazmul Huda, Ms Tahera Sultana, Ms Mahbuba Hoque, Ms Hasina Khatun, Ms Rowshan Ara Akhter, Mr Kabirul Islam Goldar, Mr Sk. Moinul Bashir and Ms Farida Khanam formed the interview teams. In a very real sense, the study's success is due to the expertise of the field teams.

We also express our deep gratitude to Mr Ali Noor, Mr M. Nasiruzzaman and Dr Kanta Jamil of USAID, Dhaka, for their close interest in the progress and outcome of this study. Ms Nancy Piet-Pelon, consultant to the Population Council, Bangladesh, took the trouble to read the main report in draft form very thoroughly, and her comments have helped to shape the arrangement of the material presented in the main report and this summary. Nancy and my colleague Dr Kim Streatfield also provided valuable comments on final drafts of the summary. The collegial support and interest of other colleagues in the office of the Population Council, Dhaka, is also acknowledged with gratitude. We hope that the study is worthy of the contributions made by so many people.

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List of Abbreviations

ACPR	Associates for Community and Population Research
AIDS	Acquired immune-deficiency syndrome
CPS	Contraceptive Prevalence Survey
DHS	Demographic and Health Survey
FP	Family Planning
FWA	Family Welfare Assistant
FWC	Family Welfare Centre
FWV	Family Welfare Visitor
HIV	Human immune-deficiency virus
ICDDR,B	International Centre for Diarrhoeal Disease Research, Bangladesh
IUD	Intra-uterine device
MCH-FP	Maternal and Child Health - Family Planning
NIPORT	National Institute of Population Research and Training
SRS	Sample Registration System
STD	Sexually-transmitted disease
THC	Thana Health Complex
USAID	US Agency for International Development
WFS	World Fertility Survey

Summary and Implications for Reproductive Health Policy

- A sample of 150 women and 141 men from rural areas of Bangladesh, including 128 matched couples, were interviewed in depth about their reasons for use of family planning methods.
- About half of the sample were users of 'traditional' methods. For the purposes of the study, 'traditional' methods were defined to be the safe period method (periodic abstinence), *azal* (withdrawal) and use of herbal preparations.
- Use of 'traditional' methods has been seen as an impediment to achieving the aims of the national family planning program, and officially discouraged. This is because they are considered to be ineffective methods with high failure rates.
- Users of 'traditional' methods often use them in combination, or with condoms, and so it is difficult to know to which method a failure should be attributed.
- The study found a number of cases where three methods (safe period, *azal* and condoms) were in use, and the majority of users of any of these methods also used another.
- The narratives from respondents suggest that failures occur because users do not have enough information about the workings of their own bodies to distinguish the safe period effectively.
- However, 'traditional' method continuation is in the long term as good as or better than continuation with the main program methods.
- This is because many users of the main program methods discontinue use due to side effects or health concerns, without immediately adopting another method. The majority of these women then become pregnant without resuming a method.
- Higher use of traditional methods occurs at both ends of a woman's reproductive cycle, and is particularly common among adolescents in the interval between marriage and first birth.
- Early onset of childbearing is a critical issue in Bangladesh, so use of methods of family planning by young couples without children is a matter of considerable policy interest.
- About one-third of the women (48 of 150) and one quarter of the men (38 of 141) in the study said that they believed that use of modern methods such as pills, injectables and IUDs can impair the reproductive capacity of the woman, particularly before her first birth.
- We also found that 33 per cent of the women and 50 per cent of the men, when asked, felt that the reproductive capacity of a woman should be proved before any method of family planning is adopted.
- Nevertheless, 41 per cent of the women and 30 per cent of the men in our sample said that a family planning method could be adopted by a couple before the first child was born.

- For comparison, about 28 per cent of women entering first marriage in the five years before the 1993-1994 DHS used some method of family planning before the first birth, and the figure gradually increased over the period.
- Many respondents to our survey approved of delaying births to very young women until they matured physically and developed socially. It was also clear that some mothers-in-law encouraged delay of the first birth.
- **There are two policy implications:**
 1. **The family planning program needs to target the reproductive health needs of adolescents more effectively;**
 2. **The wide-spread misconceptions surrounding the use of hormonal methods need to be overcome.**
- **We also propose an educational campaign on basic reproductive physiology, such as the structure of the menstrual cycle and the timing of ovulation. This would assist users of modern methods and avert failures among users of 'traditional' methods and condoms.**
- Among respondents in our survey who expressed approval of dissemination of such information, women preferred one-on-one transmission of information, while men preferred transmission through radio and television.
- Information obtained from an existing radio program, however, was often unsuccessfully retained.
- Information should be received by both women and men at the same time, because use of the 'traditional' methods and condoms requires men to be involved.
- **We believe that the solution is to develop clear diagrammatic material suitable to be given to women to share with their husbands.**
- We found a widespread belief that Islamic religious leaders opposed methods of family planning and that they campaigned actively against permanent methods of family planning, raising the policy question of mobilizing religious leaders to advocate use of family planning methods to overcome misconceptions among rural people.
- While most of the women and a substantial minority of men in the sample believed that use of any family planning was sinful (particularly sterilization), the majority felt that their families' needs outweighed religious teaching in this regard.
- Many respondents pointed out that it was a greater sin to bring children into the world if they could not be fed, clothed and educated properly.

Chapter 1. Introduction

Aims and methods of the study

According to estimates by Population Action International, cited by Rogow and Horowitz (1995:140), in 1991 there were approximately 38 million couples worldwide relying on the method of withdrawal to prevent pregnancy, and a further 30 to 35 million relying on periodic abstinence from sexual intercourse. Together, these constituted perhaps one quarter of all users of temporary methods of family planning worldwide. Similarly, according to analysis of data from the Demographic and Health Survey 1993-1994 (Mitra *et al.*, 1994), more than twenty per cent of users of temporary methods were using periodic abstinence or withdrawal.

The reasons for use of 'traditional' methods at this level has not been investigated in Bangladesh nor in most other countries. Given that the use of 'traditional' methods is widespread, what is the level of knowledge about the safe periods of the monthly cycle for the most effective use of the method of periodic abstinence? This method requires specific knowledge to be effective. If correct knowledge of its use is present in the population, how is that information being transmitted now? What are the factors which cause the higher socio-economic groups to be the main users of 'traditional' methods? It is evidently not a question of lack of access to modern methods, so is it a question of higher regard for methods which do not require chemical or physical interference with natural functions? Does lack of access to modern methods contribute to the relatively high use of 'traditional' methods among the youngest age groups? If preference for 'traditional' methods is a major reason for their use, what are the implications for family planning program activity in Bangladesh? The main report of this study investigates these questions (and others) to determine the main policy issues and the policy implications of findings. This summary report concentrates on summarizing findings with policy implications.

A field study was undertaken in the 'comparison' areas for ICDDR,B's MCH-FP Extension Project (Rural), in Kesabpur and Bagerphara *thanas* in the west of Bangladesh near Jessore, and in Satkania *thana* south-east of Chittagong in the south of the country. The Sample Registration System (SRS) for people living in these areas could be used to select a sample with a larger number of users of 'traditional' methods than would be found in a random sample of the population. Structured in-depth interviews were used to investigate knowledge about family planning methods and attitudes to their use. The study design is described in the main report (pp. 3-4).

Women and men were interviewed separately using different instruments, each with four substantive sections: respondent's background; children and pregnancy; family planning; religiosity. There were various types of questions, most of which can be found in standard survey instruments. However, in-depth questions of quite a different style were also used. They were organized as 'topics' for discussion, usually with a list of sub-topics. The interviewer discussed the topic in depth with the respondent, choosing his or her own words to introduce the topic and judgment about how to proceed with the discussion. Meanwhile, a notetaker recorded the discussion, concentrating on the responses of the respondent.

The final sample included 150 women and 141 men, from whom there were 128 matched couples. Translation of the in-depth interview material from Bangla into English was begun while the interview teams were still in the field and completed in March 1997. There are important qualifications that need to be placed on the interpretation of this information. These qualifications arise from the process by which information was collected and processed. Note-takers cannot record every word that is said by respondents, nor can they record the tone in which a remark was made or the body language and gestures which accompany it. By focusing on recording correctly an important or striking statement, even the best note-taker can miss the content of supplementary remarks. For these and similar reasons, a proportion of the content of the interview will not be recorded in the notes, no matter how expertly taken. Translation also has the potential to introduce errors of misinterpretation on the part of the most expert of translators. Sometimes such errors can easily be identified by their context, and corrected. Emphasis can also be lost in translation, or it can be introduced. Finally, the person analysing the information and writing the results can introduce other errors of interpretation, by misunderstanding the context of a statement, by misunderstanding what the translator intended, by misunderstanding the culture-specific content of the statement and by misunderstanding the style of discourse which is being reported.

While it is important to note these qualifications about the evidence, we were acutely aware of their existence and we believe that they have not affected the results of the study to any major extent.

Classification of family planning methods

Use of the word 'traditional' implies an expectation that users of methods which come under its ambit represent a group of people who want to limit their families or space their children apart but who for one reason or another do not have access to 'modern' methods, or perhaps even that they are bound by cultural values to shun modern methods. This expectation has been modified by studies in another south Asian country, Sri Lanka (Caldwell *et al.*, 1987; DeGraff and de Silva, 1991), where it was found that far from being used because no modern methods were available or accessible, methods such as periodic abstinence and withdrawal were the family planning methods of choice for many couples. Caldwell and his co-authors (1987: 12-13) point out that what is called a 'traditional' method in the family planning literature refers to any type of contraception that was 'practised prior to the availability of the pill and the IUD in the 1960s [or] that do not depend on supplies or material objects'. This definition should be modified to allow the inclusion of traditional herbal preparations where these are used.

For reasons which will become increasingly clear in this report, we find the usual distinction between 'traditional' and 'modern' methods of family planning to be misleading, and prefer instead to distinguish what we call 'direct' methods of family planning, including condoms, withdrawal and periodic abstinence, from 'indirect' methods. Here, the term 'direct' refers to the fact that use of some methods of family planning makes sense only with reference to the occurrence or absence of sexual intercourse. The three main direct methods in use in Bangladesh are withdrawal, periodic abstinence and condoms.

The method of withdrawal is widely known by the Arabic term *azal* in Islamic societies including Bangladesh, and the term will be used throughout this report. Successful use of the method of *azal* involves avoidance of discharge of semen inside the vagina by withdrawal of the erect penis before male orgasm occurs, and to be effective it requires care and control to be exercised by the man.

The method of periodic abstinence requires avoidance of vaginal intercourse during the days of the woman's menstrual cycle in which she is most likely to be at risk of pregnancy. These at-risk days are in the middle of the menstrual cycle. Various terms are in use in Bangladesh for this method, but we will use 'safe period'. Use of any variant of the safe period method requires a degree of knowledge of the physiological process of conception and the stages of the ovulatory/menstrual cycle. The days when there is risk of pregnancy are sometimes calculated to begin at the eighteenth day before the end of the woman's shortest menstrual cycle over a twelve-month period, and to end at the eleventh day before the end of her longest cycle (Peel and Potts, 1969: 83). Here the first day of the cycle is the day when menstruation begins. If every cycle were exactly 28 days, the at-risk period calculated in this way would be from the tenth to the seventeenth day of the monthly cycle; but if a woman had more variable cycles, with the shortest 26 days and the longest 31 days in the previous twelve months, her at-risk period would be estimated to be from the eighth to the twentieth day of the monthly cycle.

Until researchers Knaus in Austria, and Ogino working independently in Japan, proposed in 1929 that ovulation occurred in the middle of the menstrual cycle, it was mostly thought that it coincided in some way with menstruation, and the period in the middle of the cycle thought to be most safe was in reality the least safe period (Peel and Potts, 1969: 80-81). Popularization of the method in Europe and North America was rapid during the 1930s because of endorsement by the Roman Catholic church.

The 'traditional' methods, with substantial contribution from the use of condoms, other barrier methods and abortion, drove all of the major fertility declines that occurred before the advent of the main modern program methods in the 1960s (Wrigley, 1969; Potts, 1985). Most of these declines were in the industrialized countries. Condoms are only considered modern because they have been adopted as family planning program methods.

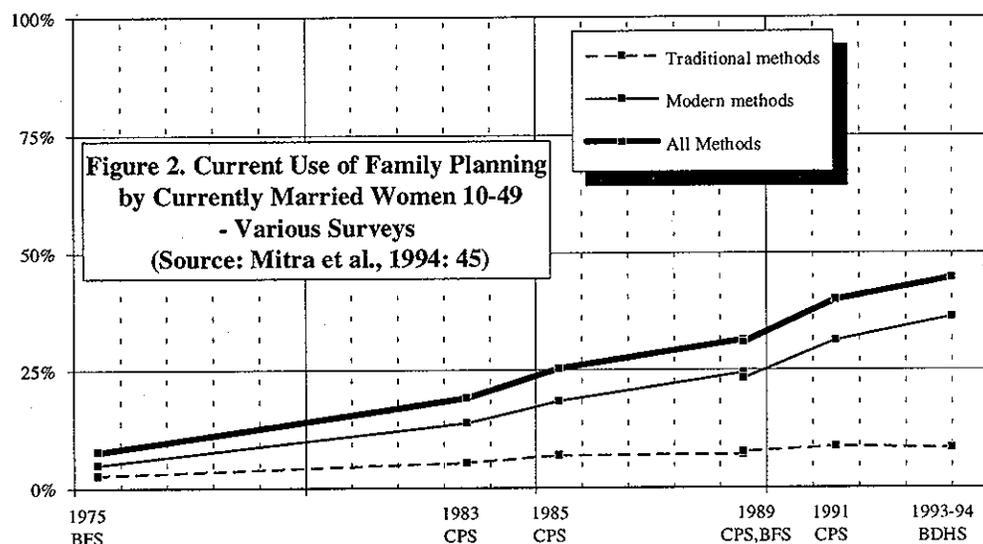
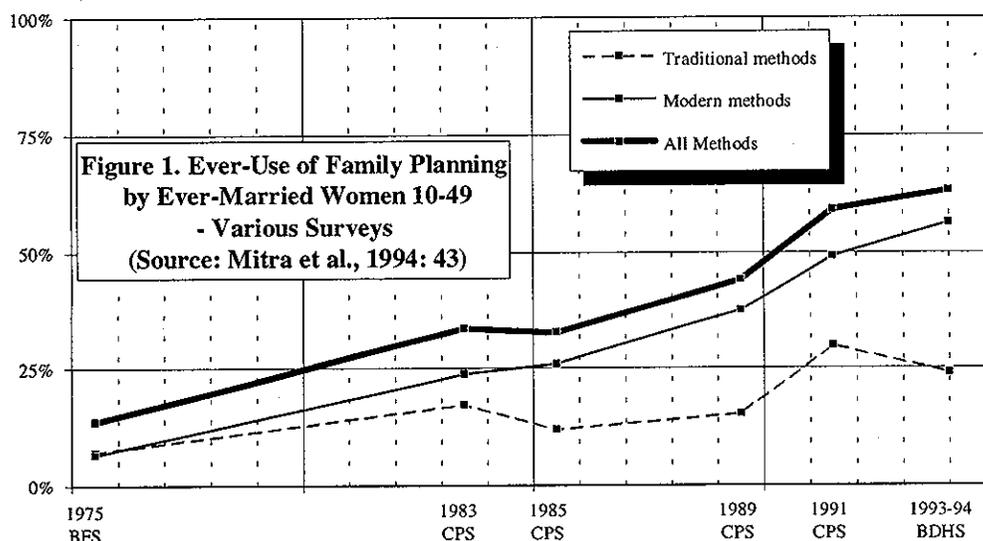
A notable feature of the family planning methods described as 'traditional', and also of the use of condoms for family planning, is that they require male involvement in their use, unlike hormonal methods and IUDs which are divorced from sexual practice and behaviour, because they can be used without sexual intercourse actually occurring. It makes no sense at all to discuss *azal* and use of condoms without reference to the occurrence of sexual intercourse, and very little sense to refer to use of the safe period method except in terms of restricting sexual intercourse to what are perceived to be the safe periods of the monthly cycle. We believe it is useful to call these three methods 'direct' methods, not only because of their direct relationship to sexual intercourse and sexual behaviour, but as will be seen because they are frequently used in combination in Bangladesh. Sensible use in combination is an important distinguishing feature of direct methods.

For example, it makes perfect sense for a couple to use a combination of *azal*, safe period, condoms and foam, with *azal* being used in what are identified to be the safe periods of the cycle, and condoms with foam being used in the at-risk days. We will argue that, in the way they are used in Bangladesh, the direct methods of family planning are used in combination so often that they are largely indistinguishable. It makes little sense to use an indirect method in combination with other methods, unless the user is unsure of the effectiveness of the method. Most of the literature on family planning ignores this distinguishing feature and makes the assumption that couples use no more than one method of family planning, or if more than one then one primary method with a supplementary method. There is also an assumption that it is possible, meaningfully, to contrast users of 'traditional' methods with users of 'modern' methods (including condoms) without overlap.

The family planning program in Bangladesh does not promote 'traditional' methods in any form, because of the perception that they have unacceptably high failure rates.

Survey evidence of use of 'traditional' methods in Bangladesh

In the demographic surveys of every country, reporting of use of 'traditional' methods is inconsistent and probably incomplete (Caldwell, 1985). There is abundant evidence of misreporting in Bangladesh. Figure 1 shows ever-use of 'traditional' and 'modern' family planning methods by ever-married women, according to a number of surveys. Since it is inconceivable that the fluctuations in the proportion of ever-married women who have used 'traditional' methods could be genuine, it is wise to adopt the view that care should be taken in interpreting the information from any one survey.



The inconsistencies are less visible if current contraceptive prevalence among currently-married women aged 10-49 is considered. Figure 2 illustrates that both 'traditional' methods and 'modern' methods have been increasing in prevalence over time in Bangladesh, with the prevalence of 'modern' methods increasing more quickly.

The use of family planning methods, including 'traditional' methods, is conditioned by the stage of the family life cycle (see main report, pp. 16-17). There are two distinct types of use of the 'traditional' methods. The first type is an increased level of use of 'traditional' methods before a couple has any children, among couples who use a method at all at this stage of the family life cycle. The second type is an increased level of use of 'traditional' methods at older ages. If 'traditional' methods find favour at the beginning and at the end of the procreative phase of the family life cycle, there must be a considerable amount of switching between 'traditional' and modern methods during the years between marriage and menopause.

Chapter 2.

Method failure and patterns of method use

Survey evidence of method failure

Using 1993-1994 DHS data for the period from April 1988 until the date of the survey (November 1993 to March 1994), it can be shown using the methods of survival analysis that about 8 per cent of women who married during this period would use one of the 'traditional' methods of family planning before the birth of their first children, compared with 19 per cent who would use a modern method (main report, pp. 19-21). Almost two-thirds of the women would become pregnant within five years before adopting any method of family planning. Most of the women who adopted family planning methods in this way did so in the very first month of their unions, and there was significant increase in the proportion who did this during the five years before the survey.

After a woman's first birth has occurred, most women adopt some method of family planning before another pregnancy occurs (main report, pp. 22-24). The same happens with subsequent births. However, only 15 per cent of those who adopt a method of family planning within five years adopt a 'traditional' method, in the case of first births, and the number is even lower in the case of subsequent births, at 13 per cent.

Given that most women adopt some method of family planning after a birth before they become pregnant again, the next step is to examine what happens when they start to use different methods (main report, pp. 24-26). For each method, the possibilities are indefinite continuation, switching to another method, method failure and method discontinuation (for various reasons) without adopting another method. All methods modern and 'traditional' have a substantial amount of attrition due to method-switching, but method-switching is at higher intensity for use of IUDs, injections and condoms. It is lowest for users of 'traditional' methods.

However, attrition due to method failure, is highest for the 'traditional' methods (within five years, 16 per cent of users of either the safe period method or *azal* become pregnant). Also, users of the safe period method are the most likely to discontinue because they want to become pregnant (28 per cent), no doubt reflecting the relatively high use of 'traditional' methods by women who have not yet experienced a birth. Users of condoms are also relatively more likely to discontinue use because they want to become pregnant, followed by users of the oral pill then users of *azal*. Users of IUDs and injectables are much less likely to discontinue use for this reason.

Very high numbers of discontinuations, without adopting other methods, are said by respondents to be due to side effects or health concerns, in the case of users of the oral pill (22 per cent), IUDs (25 per cent) and injectables (29 per cent). The proportion for condom users is very much lower, at about 6 per cent, and the proportions for users of 'traditional' methods are negligible, less than 1 per cent for episodes of use of the safe period method and less than 2 per cent for *azal*.

The proportion of women who would be left after five years from a cohort who began to use each method is by definition (Jejeebhoy, 1990, cited in Steele *et al*, 1996: 12) the method continuation rate at five years. This continuation rate is highest for the two 'traditional' methods, despite the occurrence of relatively high numbers of failures with

these methods (main report, pp. 26-27). However, continuation rates at shorter periods of use are generally higher for oral pills and IUDs.

An evident question to ask is what then happens to women who discontinue a program method because of side effects or health concerns, and who do not adopt another method of family planning. A large proportion of these women eventually become pregnant (60 per cent within five years) before they adopt another method of family planning, and 24 per cent become pregnant within three months (main report, p. 27).

Limited success of the family planning program's efforts to deal adequately with actual or perceived side-effects of the main program methods results in far more unwanted pregnancies than method failure. Yet, a woman who can use a hormonal method or an IUD without problems will evidently have greater protection against unwanted pregnancy than a user of direct methods. The dilemma for the family planning program involves dealing with health concerns of users as against supporting methods that are more failure-prone but actually result in comparable and eventually higher levels of continuation.

The field study evidence about method failure

We will now present information from the field study to illustrate particular cases of method failure. Women were asked whether they had ever become pregnant while using a method of family planning, and what their perceptions were about the causes of their unwanted pregnancies. Excluding women who had never given birth or never used family planning, 19 out of 113 (17 per cent) reported that they had become pregnant while using family planning. There were cases of repeated method failure. There were also four reported cases of menstrual regulation or other abortion following method failure. Only four of the method failures did not involve 'traditional' methods of family planning.

In the first of five cases of apparent failure of the safe period method (main report, pp. 31-32), it appears that the woman and her husband had never relied on only one method of family planning. At the time of the unwanted pregnancy they were using an incorrect version of the safe period method, intruding into the at-risk period, in combination with *azal*. It is difficult to be sure whether the failure was due to the incorrect use of the safe period method, or to a primary failure of *azal*. After obtaining more correct, but still incomplete, information about the safe period method, at the time of the survey she had been using the safe period method in combination with condoms for thirteen years, since age 22.

The first of two unwanted pregnancies of one woman (main report, pp. 32-33) occurred, in her opinion, because although she used an approximation to the safe period method in which she did not have intercourse for fifteen days after the end of her last menstrual period, she was not always able to remember to count the days accurately. She then switched to use of oral contraceptive pills, about the use of which she remained very ambivalent. The other unwanted pregnancy resulted, in her narration, from irregular pill supply but no doubt her ambivalence about pill use contributed, because she was well aware of other sources of supply.

In another case of failure of the safe period method (main report, pp. 33-34), the woman not only had a tenuous version of the method, but had given the same version to other women with the result that they also became pregnant. The version of the method that she was using stated that the first eleven days after the commencement of menstruation constituted the safe period, and she interpreted this to mean the first week after the

cessation of bleeding. After the method failure, which can only be attributed to poor understanding, she switched to the other main 'traditional' method (*azal*) and later abandoned that in favour of pill use to regulate her menstruation.

The consequences of incorrect understanding about the safe period method could not be more clearly illustrated than in the experience of a woman who believed that the at-risk periods of the monthly cycle were the ninth and the twenty-first days after the end of menstruation (main report, pp. 35-36). We took care to verify that this is what she believed. This misunderstanding is a startling reminder that it is lack of information that disempowers women. While this version of the safe period method is astonishing, it is easy to see how it came into being as a result of two transformations from a version which is known in Bangladesh. The original version would have specified the ninth to the twenty-first day from the beginning of menstruation as the at-risk period.

Lack of information about the safe period method, and a failure with its use, did not deter another woman from reverting to its use after perceived unsatisfactory experience with other methods (main report, pp. 36-37). The version of the safe period method currently used by the woman appeared to be a less safe version than she was using at the time of the method failure. To account for the method failure, at first she stated that she had made a mistake in counting the days, but then she seemed to express some certainty that the conception had taken place after the 21st day of the menstrual cycle.

In contrast with cases of failure using the safe period method, failures of *azal* mostly have simple explanations. There were seven reported cases of pregnancy occurring during use of the method of withdrawal (*azal*). In the first case (main report, pp. 37-38) the woman maintained a positive attitude towards *azal* even though it caused a method failure. The failure was attributed to her husband, as a single remembered occasion. The failure resulted in resort to an indigenous abortion given by a *kabiraji*. She had then adopted the theoretically safe method of injectables, but experienced serious supply problems and irregular menstruation from their use.

The next case of *azal* failure (main report, pp. 38-39) also involved a radical method switch, to vasectomy. This woman also appears to refer to a single remembered occasion of 'forgetfulness' on the part of the husband. In another of the cases of *azal* failure (main report, p. 39) the woman said that the method was followed rigorously, but the man indicated that he might have been aware that a 'miss' occurred. The next case of *azal* failure (main report, pp. 39-40) resulted in an abortion by menstrual regulation. In this case there is no single remembered occurrence of failure of *azal*. It seems more in accordance with the narration that the husband was unable to perform *azal* properly on more than one occasion. After the pregnancy was aborted, this couple seems to have given thoughtful consideration to the choice of the contraceptive pill, which they subsequently used. There is a similar case (main report, p. 40-41), in which repeated failure to control ejaculation seems to have led eventually to a pregnancy. This couple was at the time of the interview using the oral contraceptive pill, but the man was continuing to use withdrawal out of habit.

Two method failures, one from *azal* and the other from condom use, were reported in another interview (main report, pp. 41-42). This couple had problems with all the methods they tried, although some of the problems mentioned, such as ulceration, could have been caused by reproductive tract infections. At the time of interview the woman was using what

was purported to be a contraceptive medicine from a homeopathic practitioner.¹ This woman's youngest child was aged only seven months, so the potential for another method failure and the birth of a seventh child through use of an ineffective method was clearly present.

Alternative medicinal practice relating to contraception exists in Bangladesh. Besides homeopathic suppliers and practitioners, there are also 'village doctors', who are self-taught practitioners of all types of medicine including allopathic methods. There is another type of supplier called a *kabiraji*, who makes traditional herbal preparations using plants and their bark, roots and seeds. Some make preparations which they claim will prevent pregnancy, and a number of cases of failure of this type of method were narrated to us.

The first case (main report, p. 42) was not complicated. The woman perceived the use of *kabiraji* preparations to have been fraudulent, but it was not a case of a once-only experimentation that failed. The case of this woman is interesting from another aspect, because she subsequently gave up modern methods in favour of what she called the 'safe period method', but which was actually use of the safe period in combination with use of condoms and *azal*.

In another case of *kabiraji* method failure (main report, pp. 42-43), the woman referred briefly to a failure of the safe period method as well. A failure due to misinformation seems likely. Her use of a *kabiraji* method (in the face of opposition from her husband and the FWA) resulted in her having menstrual regulation, and she stated forthrightly that she would never use a *kabiraji* method again. This woman had then cast around for a suitable method to use, and settled on the oral pill.

Another woman who had a *kabiraji* method failure was currently pregnant after abandoning family planning method use. This case illustrates the broader sense of method failure in which perceived method side-effects lead to the abandonment of family planning method use and lapse into unwanted pregnancy (main report, pp. 43-44). There was nothing complicated about the failure of the *kabiraji* method. The woman related her subsequent unsuccessful attempts to find an effective method of family planning suitable for her. There is every indication that her attempts were committed and with urgent intent, given that she had already had a large number of children.

One case of failure with use of condoms, attributed to rupture, has already been mentioned. In that case, the woman had also had an *azal* failure. There are several other cases attributing pregnancy to instances of condom rupture. In the first case (main report, p. 45), the woman referred to side-effects of the oral pill, which apparently resulted in use of condoms instead. After the method failure produced the seventh child of this couple, the husband had a vasectomy.

¹ The interviewers were told of these medicines by respondents in both geographical Divisions of Bangladesh in which this study was carried out, and we obtained a package with one remaining pill from one woman. The package was a small factory-produced plastic jar with professionally-produced labelling and instructions. Each package was meant for one month of use, with the instruction to take three pills after each occurrence of intercourse. We have not had the pill analysed. Homeopathic practitioners are found throughout Bangladesh and in other parts of south Asia, using a form of medical practice derived from the tradition developed in Europe in the nineteenth century. It is likely that at least some of the contraceptive pills supplied in this way in Bangladesh are hormonal preparations, but because of their source they are perceived by their users not to have the side-effects which are widely reported for pills supplied under the family planning program.

In another case of a burst condom (main report, pp. 45-46), the woman and man had had long experience with effective use of family planning, beginning with use of an IUD to space their first and second children, and again the second and third children. Due to what is undoubtedly a genuine side-effect, profuse bleeding, she eventually gave up IUD use and tried other methods. At the time of the survey she and her husband were using a version of *azal* in which they used condoms on some occasions to ensure that no accidental ejaculation occurred in effecting withdrawal. The woman was understandably apprehensive about another method failure, because she had apparently already had a condom failure and her husband could not always avoid ejaculation while using *azal*. She was still less than 30 years old and they clearly remained at risk of having more than the four children they already had.

Reference to 'burst' condoms, also translated as 'ruptured' condoms, was recorded in twelve of the interviews with women and eight of the interviews with men in this study. There was not a single case where both the man and the woman from one household mentioned this phenomenon, including the three men whose wives said that 'burst condoms' caused pregnancy. All three said they had used condoms, among many other methods. One said that he was still using condoms. His account of contraceptive use (main report, p.47) shows no apprehension about use of condoms and does not seem at all like the account of a person who has had a condom method failure, and his account of its use indicates he adopted it after the unwanted pregnancy. We should consider the similarity between breakage of a condom and *azal* failure. Both have the same effect, namely unwanted release of semen inside the woman's reproductive tract. In the next section of this chapter, we discuss the possibility that 'conventional accounts' are sometimes given to explain events which in some way confront social conventions. Without doubting that condoms sometimes burst, we leave open the possibility that accounts of rupture might sometimes be a reference to something else.

While modern method use does carry with it the risk of failure, the one instance of conception after use of the oral pill can hardly be called a failure of the method (main report, pp. 47-48), because the woman would take pills only on the nights on which she had intercourse, and often discontinued use. Both children of this young woman were apparently born after risk-taking behaviour, but after their birth she had taken more stringent steps to avoid further pregnancies. A lackadaisical approach to contraception can be adopted by a young woman for the simple reason that she wants to have children at some time and so it does not necessarily matter to her if they come in a less planned manner.

One case of failure with use of an IUD was reported (main report, pp. 48-49). It appears to have been a straightforward case of pregnancy occurring with an IUD in place. At the time of the interview she was using the safe period method and condoms if she had intercourse during the first 21 days of the menstrual cycle. The progression from a method that is theoretically highly effective, but failed, to hormonal methods which she says caused side-effects, and then to a variant of the safe period method was not the result of disregard for the effectiveness of IUD use. It was based on rational choices, by the woman and her partner. She was considering using an IUD again.

‘What method of family planning are you using?’

A premise of the entire program of Demographic and Health Surveys (DHS), before them Contraceptive Prevalence Surveys (CPS) and before them World Fertility Surveys (WFS) carried out in most developing countries at intervals during and since the 1970s, has been that a universally-applicable set of questions can be asked to women to get an accurate answer to this question. The questions have been asked with little variation from a basic formula derived for the WFS. Women were asked first which methods of family planning they had heard of, prompted for any that they omitted to mention, then asked which of the methods they had heard of that they had ever used and finally which methods they were using at the time of the interview.² The list of methods used for prompting and to determine which methods have ever been used, is also given in a fixed order. Modern methods beginning with the oral contraceptive pill are at the top of the list and ‘traditional’ methods at the end. This approach produces consistency between countries and between different surveys conducted in a single country. Whether the approach produces accuracy or not is quite a different question.³ For example, it was noted in the report of the 1993/94 Bangladesh survey (Mitra *et al.*, 1994.: 124) that the same sequence of questions asked to a sub-sample of husbands produced answers that were markedly inconsistent with their wives’ answers.

We took a different approach to the questions, in which respondents were given descriptions of the ‘traditional’ methods before being asked if they had ever heard of them, and we did not seek to obtain so-called unprompted responses about whether respondents had ever heard of any methods. Since we felt that the relegation of the ‘traditional’ methods to the end of the list of methods was one factor contributing to under-reporting of their use, we elevated them to the beginning of the list. We also encouraged respondents to reveal if they were using a combination of methods.

There were many instances in the survey where there was fundamental disagreement between man and woman over which method of family planning they were using, even with this modified approach. Most of these disagreements involved direct methods. Excluding 35 interviews where either the husband or the wife was not interviewed and 4 cases where the woman was pregnant, there were 124 matched interviews. In 71 cases (57 per cent), the man and the woman either agreed that they were not using any method of family planning (19 instances) or else they agreed on the method or methods that they were using (52 instances). There were another 15 cases (12 per cent) where there was agreement on at least one method but other methods in current use were mentioned by one partner or both. This left 38 cases (31 per cent) of apparently fundamental disagreement between the man and the woman about whether they were using any method at all (17 instances) or where the woman said she was using one method and the man said he was using a different method (21 instances).

In Chapter 4 of the main report, each of the cases of disagreement about methods in use is investigated in detail to determine how the discrepancies could have occurred. It was found, firstly, that most of the users of indirect methods agreed about which method they were using, and most of the users of direct methods (safe period, *azal* and condoms) did not, as shown in Table 1.

² The original version is set out in the core documentation for the World Fertility Survey (1975).

³ Originally the approach was not expected to produce accuracy, as noted in the core documentation for the World Fertility Survey (1975: 14).

This pattern is extremely similar to that reported by Mitra and his co-authors (*op. cit.*: 124) for the 1993-1994 DHS. It can be seen that in the case of users of pills, IUDs and injections, a majority of both female and male users agree with their partners about their use of these methods. This is not so in the cases of users of any of the direct methods, including condoms. The disproportions are just as great in the DHS data.

Where both woman and man agreed on the methods of family planning that they were using, only four reported use of more than one method. All of these said that they used the safe period method in combination with *azal*. One explanation for use of these two methods in combination was incomplete understanding of the at-risk period, and consequently a need to use some way of avoiding pregnancy during very long periods of the menstrual cycle perceived to constitute the 'danger period'.

Method	Both woman and man report use	Only woman reports use	Only man reports use
Safe period	6	19	25
<i>Azal</i>	9	28	18
<i>Kabiraji</i> method	3	7	6
Oral pill	15	21	26
IUD	2	2	3
Injection	12	12	13
Condom	7	16	18
Tubal ligation	2	2	2
Vasectomy	-	2	-
Other	-	2	1
No method	19	31	21

Note: Multiple responses are recorded where more than one method of family planning was reported.

Two couples reported use of the safe period method alone, and four more reported use of *azal* alone. In one case of reported use of *azal* without concurrent use of any other method, the man's interview revealed that they actually only used *azal* in the at-risk period of the cycle. They used *coitus reservatus*, rather than the more usual form of *azal* ('dropping semen outside'). This man and woman were actually using the safe period method in combination with *azal*.

Men and women using a combination of direct methods of family planning often do not say so at first, or do not mention the same combination of methods. There were fifteen instances in the interviews where the man and the woman were in basic agreement about one or more methods of family planning that they were using, but where additional methods were also mentioned by either the man or the woman. All of these cases involved use of 'traditional' methods, and the most frequently found combinations were various permutations of use of the safe period method, *azal* and condoms. In three cases, all three of these methods were mentioned by one of the respondents. Table 2 sets out the fifteen cases, with agreed methods in bold type.

There are four unusual combinations (case numbers 020, 021, 085 and 096). In the first of these, where the man mentions using *azal* as well as oral pills, he was basically using *azal* on occasions because he distrusted his wife's ability or willingness to take the pill without his supervision. The next case, where the woman mentioned using a *kabiraji* preparation in addition to practising *azal*, the fact was that she distrusted the *kabiraji* method and could hardly be said to be using it. The next case referred to the very unusual combination of safe period, mentioned by the man, with the oral pill, the use of which both woman and man acknowledged. The woman also revealed use of the safe period method, but she did not explicitly say she was still using it. This man and woman were primarily pill users, but not rigorous and consistent in use because of real or perceived side-effects. In the last of these four cases, the woman said that they used *azal* as well as the pill which both admitted. From her account, the primary method being used was *azal*, with pills being used improperly as a back-up.

Table 2. Cases of agreement between man and woman about method in use, but additional method(s) mentioned by at least one

Case number	Methods in use according to:	
	Woman	Man
10	<i>Azal</i> ; condom	Safe period; <i>azal</i>
14	Safe period; <i>azal</i>	<i>Azal</i> ; condom
15	Safe period; condom	Condom
20	Oral pill	<i>Azal</i> ; oral pill
21	<i>Azal</i> ; <i>kabiraji</i> method	<i>Azal</i>
27	Safe period; <i>azal</i>	Safe period
35	Safe period; <i>azal</i>	Safe period; condom
53	Safe period; <i>azal</i> ; condom	Safe period
67	Safe period; <i>azal</i> ; condom	Condom
85	Oral pill	Safe period; oral pill
87	Safe period; condom	Condom
96	<i>Azal</i> ; oral pill	Oral pill
104	Safe period; condom	Safe period
140	<i>Azal</i> ; condom	Condom
148	<i>Azal</i> ; condom	Safe period; <i>azal</i> ; condom

If one of the three direct methods (safe period method, *azal* and condoms) is mentioned by the woman, and another of the three direct methods is mentioned by the man, and they agree on at least one method in use, then investigation of the cases shows that they are probably using a combination of all the direct methods that they mention.

In the first of the cases where all three direct methods were mentioned, the woman simply filled in the details of what the man really meant when he said that they used the safe period method, by explaining that they used condoms and sometimes *azal* in the at-risk period. The second case was similar, except that the man claimed to be using only condoms. In the third case, it is the man who referred to use of all three methods, but the woman said she had not heard of the safe period method and agreed that they used the other two direct methods.

There are three other cases in Table 2 where all three direct methods are mentioned, but not by either the man or the woman alone. These cases also appear to be combinations of all three methods. In the first of the three, it seemed that the man had a very poor understanding of the safe period, although he said he used it, while the woman claimed no knowledge of the safe period method. In the second case the man and woman disagreed about when they used *azal* and if they used condoms at all, and while he said he did not use the safe period method, in part of the interview the man did say 'From the ninth to the nineteenth day of menstruation I use condoms'. In the third case the woman said she used *azal* in disagreement with the man's claim to use condoms, although they agreed that they used the safe period method.

The cause of these differences is that there are problems for respondents who use direct methods to answer questions on method use. If they have not yet had sexual intercourse in the current cycle, then they can only have an intention to use a method or methods, and the same observation applies if they use a combination of methods but they have not yet reached the stage of the cycle when they would normally switch over to another method. If they are not necessarily referring to the current cycle, then they must be referring to their usual or recent practice; but if they are using a combination of methods, the method mix might change slightly from month to month, and the man and woman might have different memory or perceptions of what they have done recently.

There were seventeen cases where either the man or the woman said that they were using a method of family planning but the other did not. It is possible in most of the cases to explain the differences between the men's and women's stories, with only two cases of total incompatibility between the man's account and the woman's. A summary of the cases is given in Table 3.

There were only two cases where the woman reported use of a method when the man did not. In one of these cases (034), the man's interpretation of the term 'family planning method' was restricted to program methods. He did not consider *azal* (or any other method that did not involve 'medicine' from a doctor) to have a bearing on family planning. The other case (082) involved use of a *kabiraji* preparation by the woman, on the advice of her aunt, after she had borne ten children of whom only four were still living (three daughters and a son). She appeared to have done this without the knowledge of her husband.

Of the cases where it was the man who reported use of a method when the woman did not, there are several groups. The first of these is 'use' of a direct method when intercourse is rare or absent (case numbers 55, 100, 151). There is a related group (046, 134, 136) where reference is made to past or intended use of a direct method. These cases provide additional reasons that answering questions about method use is more difficult for users of combinations of direct methods than for users of indirect methods. Where intercourse is rare a direct method can at best be used occasionally. If amenorrhea occurs use of the safe period method is logically impossible but reported use can refer to firm intention or past practice.

There are two cases where the man says that the woman is taking oral contraceptive pills, but the woman herself does not say so. In one of these cases (033), her non-use is because she has no supply in the current month. In the other case (061), they probably do take pills from the FWAs, but pill supply does not necessarily imply use.

Case no.	Method reported by:		Explanation
	Woman	Man	
033	-	Oral pill	No supply in current moth
034	<i>Azal</i>	-	The man interprets 'method' as meaning program methods only
046	-	Safe period	The woman is still amenorrheic after the birth of a child, so use of the safe period can refer only to intention to resume
048	-	<i>Azal</i>	The woman wants another child but the man does not
049	-	Safe period	Both say they want another child, but the man is adamant that he is still using the safe period method, for no clear reason
055	-	Safe period	The man counts the days (controls the method), but sexual intercourse is either rare or absent
056	-	Ayurvedic pill; <i>azal</i> ; safe period	The woman states that she has never used a method but her husband has!
061	-	Oral pill	Pill supply does not guarantee pill use
066	-	<i>Azal</i>	The woman does not regard <i>azal</i> as reliable, but indicates that they have used it. They have avoided pregnancy for 19 months since marriage.
079	-	Safe period	The woman distrusts the safe period method, but indicates that they use it.
080	<i>Kabiraji</i> preparation	-	The man wants another child, but the woman took a <i>kabiraji</i> preparation on the advice of her aunt after many infant deaths
100	-	Safe period	The man is an ascetic, and sexual intercourse is very rare. He might have followed the safe period method in the past and still regards it as the method he uses
125	-	<i>Azal</i>	[Accounts not compatible]
128	-	Injectable	[Accounts not compatible]
134	-	Safe period	The woman is close to menopause with rare menstruation and use of the safe period method refers to past practice
136	-	Safe period; condoms	The woman is still amenorrheic after birth of a child, and the man's account refers to past and intended practice
151	-	Condoms	Intercourse is very rare

Table 4 shows the 21 cases where the man and woman agreed that they were using a method, but did not agree on which method. There were only three cases where no

explanation for the discrepancy can be offered. A detailed discussion of the individual cases is given in Appendix Four of the main report. The most common reason for the inconsistency is reporting of different aspects of use of a combination of direct methods.

Case no.	Method reported by:		Explanation
	Woman	Man	
009	<i>Kabiraji</i> treatment	Oral pill	The woman's menstruation has only recently returned after lactational amenorrhea; she says she then took a <i>kabiraji</i> treatment. The man is referring to past use of oral contraceptives
017	Vasectomy	<i>Kabiraji</i> sterilization of woman	Conventional account of vasectomy - see text
025	Safe period; <i>azal</i>	Oral pill	The man appears to be stating a preference rather than describing actual practice
028	Safe period	Abstinence	No sexual relations; if there were they would use the safe period method
031	<i>Azal</i>	Safe period	Both methods used
040	<i>Azal</i>	Safe period	Both methods used
045	Safe period	Oral pill	The man's claim that they switched to oral pill use might reflect a desire to answer questions in the way he thought was wanted
051	Oral pills - homeopathic	Oral pill	The man makes no distinction
072	<i>Azal</i> ; oral pill	Safe period	Habitual use of safe period with <i>azal</i> , and recently including use of oral pills also
074	<i>Azal</i>	Safe period	Both methods used
078	Vasectomy	<i>Kabiraji</i> sterilization of woman	Conventional account of vasectomy - see text
088	<i>Azal</i>	Condom	Conventional account of <i>azal</i> - see text
093	Oral pill	<i>Azal</i> ; condoms	The man is unaware that his wife has resumed use of pills after suspension due to side effects
094	Condoms	Safe period	[Accounts not compatible]
095	Safe period; <i>azal</i>	IUD	[Accounts not compatible]
099	Oral pills - homeopathic	Oral pills	The man did not mention that the oral pills are from a homeopathic practitioner
101	<i>Kabiraji</i> treatment	Safe period	Both methods probably used; the woman has not heard of the safe period method
131	Safe period	Condoms	Both methods used
135	Oral pills	Condoms	Irregular pill supply
146	<i>Azal</i>	Oral pill	[Accounts not compatible]
150	<i>Azal</i>	Safe period	Both methods used

There were two cases (017, 078) where the woman said that her husband had had a vasectomy but the man said that his wife had received *kabiraji* treatment which had sterilizing effect. By comparing the accounts (main report, pp. 64-65) we believe it is very likely that the men are using what we call a conventional account of vasectomy. In a rural and largely illiterate society, the evidence of what people actually did in a given set of circumstances can be contaminated by conventional accounts, that is socially acceptable ways of describing events which confront social convention. Such conventional accounts can be adopted by a person as the explanation of his or her particular circumstances. As convenient explanations of things which it might otherwise be inconvenient to explain, these conventional accounts have high utility and can be adopted widely by individuals to explain what happened to them. If two instances of an unusual combination of reported family planning method use are reported independently by two different couples, then intrusion of a conventional account is to be suspected.

There is another instance in Table 4 (case number 088) where the most likely explanation of the woman's reference to *azal* and the man's reference to use of condoms is that they were using *azal*, not condoms. The reason for this conclusion rather than the more usual one of use of methods in combination is that in this case the man's interview not only gave emphasis to the danger of condom rupture but also attributed to condoms advantages and disadvantages that are normally cited for *azal* (main report, p. 67). It appeared to be a conventional account of the dangers of use of *azal*.

Chapter 3.

Aspects of use of 'traditional' methods

Correctness of knowledge about the safe period method

As we have seen, poor information about the safe period method is a significant contributor to failure with its use. It can be argued that lack of accurate information about the safe period method is no less than a denial to women of information about how their bodies work, apart from its contribution to unwanted pregnancies. If it is possible to deliver clear descriptions of the features of the ovulatory cycle to women and men, with the at-risk periods identified, then this would not amount to official encouragement of the use of non-program methods. It would merely recognize that these methods are already in use by a considerable proportion of the population, and allow women and men to use the 'traditional' methods less dangerously.

Correct knowledge about the safe period method was very low among the respondents to the survey, even though a quite liberal definition of the concept of 'correct' knowledge was used. The interviewer instructions (main report, pp. 69-70) were that respondents who nominated a reasonable period in the middle of the cycle as safe were to be classified as having correct knowledge, but if they only nominated either the start or end of the cycle they were to be classified as having partly correct knowledge. If they described any of the at-risk period as safe their knowledge was described as incorrect. Table 5 shows that even with this liberal definition, only 7 per cent of women who had heard of the safe period method, and 25 per cent of men, were able to give a 'correct' definition. Most of the 'partly correct' answers referred to the last week or so of the menstrual cycle as being the only safe time for sexual intercourse.

Table 5. Correctness of knowledge about the safe period method				
Assessed knowledge	Woman		Man	
	Correct	6	7%	26
Partly correct	47	55%	33	32%
Incorrect	32	38%	43	42%
Heard of method	85	100%	102	100%
Not heard of method	65		39	
Total	150		141	

Lack of correct knowledge is often attributable to the source from which knowledge was obtained. As Table 6 shows, incorrect knowledge about the safe period method is passed on by friends, relatives and neighbours more than any other source, and especially is this true in the case of women, who are also more likely to receive information in this way.

Table 6. Correctness of knowledge according to sources of information				
Source of information	Woman:		Man:	
	Received information from this source	Knowledge incorrect	Received information from this source	Knowledge incorrect
Husband/wife	9	1	20	8
Friend, relative, neighbour	58	29	39	22
FWA/FWV	14	2	11	2
Book	10	1	11	7
Village practitioner	5	1	8	2
Other	6	-	14	2
All sources	85	32	102	43

There were ten women who said they had received information from books, and in two cases these were named books nominated as sources by two women each. The books were *Shami Istrir Milan Katha* [Sex between husband and wife] and *Namaj Shikhya* [Guide to Prayer]. In all four cases, their knowledge of the safe period method was classified as partly correct, so it cannot be certain that either book gives much information. A family planning worker who had obtained information from a training course as well as books also had only partly correct knowledge. There were two women who had undergone teacher training courses and had received some information about the safe period method from books which were used in the course. One of these two women was classified as having incorrect knowledge, the second as having partly correct knowledge. Of the remaining three women who said they had received information from books, none mentioned the title of the book or where they obtained it. Only one of these women was classified as having correct knowledge, in the limited sense used here (and she had given birth ten times). It is to this extent evident that the limited references available to women in the study areas do not provide much useful information about the safe period method. Of only six women altogether who had correct knowledge, only one of these obtained the information from a book.

Husbands were mentioned as one of the sources of information by nine women, only one with incorrect knowledge. This makes husbands one of the most reliable sources.

The least reliable sources are friends, relatives and neighbours. Of seven women who obtained their information from sisters-in-law, only two had knowledge that was even partly correct. Of seven other women who obtained information from aunts and aunts-in-law, four had incorrect knowledge and three had partly correct knowledge. There were six other instances of named types of relatives from whom information had been obtained, and of these three women had partly correct information. The women who nominated neighbours and friends as their informants had information at least partly correct in fourteen out of twenty-eight cases, including two cases with correct knowledge as defined here.

While a large majority of women said that no information was available from family planning workers, there were a number of instances found where information about the safe period method had been given by workers in the family planning system. One had correct knowledge of the safe period method. Of the remaining ten cases, three women had incorrect knowledge of the method and the rest had partly correct knowledge (main report, pp. 75-76). This seems to indicate that, at best, the primary knowledge imparted by workers within the family planning service is incomplete.

It is, perhaps, surprising that almost as many men as women (11 men and 14 women) said that they had received information from family planning workers, since these workers concentrate their attention on women. There were six other cases where men obtained information indirectly, through their wives (main report, pp. 76-77). Five of these six men were classified as having correct knowledge of the safe period method. Among men who obtained information more directly from workers in the family planning service delivery system (main report, pp. 77-78), in two of these cases family relationship was involved, and in three cases the respondents reported steps they had taken to search actively for more information.

Two women referred to having heard something about the safe period method on the radio. While most men were in agreement with women that no information was ever broadcast about 'traditional' methods, there were nine men who were aware not only of information that was broadcast on the radio, but of other information in the public media, including magazines. Only three of these men had even partly correct knowledge of the safe period method (main report, p. 78), and none of these three had relied on the radio program. There is perhaps some indication here that the radio is not a suitable medium for transmitting information about the safe period method, although the program apparently has a policy of answering questions rather than giving direct information about the method. Of the two women who referred to information from the radio, one had incorrect information about the method even though she had heard about it on the radio only 'a few days ago'.

Among many of the men who had correct information about the safe period method, there is a suggestion of insider knowledge, obtained through family connections with knowledgeable people in the family planning service delivery system or other parts of the health service, and sometimes obtained from participation in training courses themselves. There were also some accounts of men obtaining information about the safe period method from sources outside the local communities to which women were much more confined.

*D*isseminating knowledge about the safe period method

Both men and women were asked whether information about the safe period method should be disseminated publicly, and if so through what media. The responses to these questions differed considerably in the cases of women compared with men, due apparently to cultural reasons. All of the women who answered the question in the negative answered by saying 'I do not want to know', rather than that information should not be disseminated (main report, pp. 80-81). Often this negative response was not elaborated. In other cases the women said they were using a different method, or no method, so they did not want to be informed. In yet other cases women felt they already knew enough about the safe period method so it was not necessary to be informed further.

Relatively few men responded in any of these ways. There was a large group of men who said that they personally did not want any information, but qualified their statements by referring to which media were most suitable if information was to be made available. They

generally referred to publicity through radio or television, with some mentioning training, or family planning workers (main report, pp. 81-82).

Out of those who had heard of the safe period method, a majority of women (56 out of 85) and a majority of men (75 out of 102) said that they wanted information about the method to be disseminated, and nominated what they felt would be the appropriate methods of disseminating the information (main report, pp. 82-83). The pattern of response is totally different in the case of women from the case of men. Men favour dissemination of information through the electronic media, particularly television, while women favour personal contact, for example with family planning workers.

*F*amily planning before first birth

Most marriages in rural Bangladesh involve the movement of a young woman into the household of her partner's parents, itself located within a contiguous group of households, called a *bari*, with other households formed from the patrilineal line. Often these women are not just young but extremely young. Tradition seeks to make their wills subservient to the wills of the families they have joined, and particularly to the wills of their respective mothers-in-law, who have experienced the same process one generation before. Apart from the relationship they form with their husbands, they can hope to form friendly relationships with their sisters-in-law and so-called 'joking' relationships with brothers-in-law.

It is possible to classify the women in the study almost completely into three groups: those who said parents-in-law wanted grand-children as soon as possible, those who said there were some parents-in-law who wanted children early and others who encouraged delay, and those who said parents-in-law (their own) encouraged them to delay having their first children.

In the first group, referring to parents-in-law who wanted no delay in the birth of grandchildren, there were 93 female respondents. In the second group, acknowledging two types of parents-in-law, were 37 respondents. And just 17 women formed the third group, referring to parents-in-law who encouraged them to delay having children. (There were three respondents who were outside this classification system for individual reasons.)

The first group contains one major sub-group, two minor sub-groups, and a group of other miscellaneous responses, with very little overlap. The major sub-group consists of those women who reported that the reason their parents-in-law wanted grand-children was because of the pleasure they obtained from having them. There were 57 respondents who gave answers in this vein. The first of the other, minor sub-group contains 21 women who referred to the concerns of parents-in-law about the health risks associated with use of family planning methods, particularly about supposed effects on the ability to conceive, but also about effects on the ability of women to carry a baby through to term and deliver safely (main report, p. 87). There were only three women who belonged to both of these groups, that is, who said that their parents-in-law wanted to see the faces of their grand-children and were concerned about health risks from the use of family planning methods. This lack of overlap indicates that these groups are quite distinct.

The same is true for the other minor sub-group, which had no overlap at all with the other two. This consisted of just eight women, who said that their parents-in-law opposed the use of any family planning methods because they were sinful.

There were a further ten women who gave various non-specific responses about the opposition of parents-in-law to the use of family planning methods, or in some cases highly specific responses which did not fall into the other three groups. Among these specific responses were references to the possibility of child death, and in one case to utter disbelief that anyone used family planning methods before the birth of a child.⁴

Among the rather large group of 37 women who referred to the existence of two type of parents-in-law, specific reference to maintaining the daughter-in-law's health occurs in more than half of the cases, and most others refer to other developmental benefits for the daughters-in-law. The main counter-factual cases refer to avoidance of any perception that the daughter-in-law was already pregnant.

Among the 17 women who refer to parents-in-law who approve of the use of family planning methods before the birth of children, there are again some cases where the approval is based on avoiding the perception that the daughter-in-law might have been pregnant at the time of marriage. Most of the women, however, refer to having parents-in-law who encourage them to delay childbirth for their own benefit (main report, p. 89). The methods said to be permissible sometimes excluded program methods.

Compared with the lucid and comprehensible responses given by women about this topic, the responses given by men are vague and often unformed (main report, pp. 89-90). The reason for this is that men usually do not know first-hand what advice or instructions are given to daughter-in-law by mother-in-law, and in many families it is not a topic for discussion between son and parents.

As we have just seen, one of the factors fuelling parental opposition to delaying childbirth is concern about the health effects of contraceptive methods, and particularly about the possibility that family planning methods can affect the capacity to conceive babies, or deliver them without trouble. It is to be expected that similar concern will be expressed by respondents themselves, and it is.

One of the most common expressions of this concern is a belief that fat accumulates in the abdomen or even in the womb as a result of use of the oral contraceptive pill, and as a result conception becomes difficult or impossible. This belief is sometimes extended to other family planning methods. There are many statements about this in the women's interviews (main report, pp. 90-91). Another frequently-mentioned health problem emanating mainly from pill use is said to be 'burning' or withering of the reproductive tract, and other specific conditions are also mentioned by some respondents (main report, pp. 91-92). Many other respondents, including some who said they did not believe it themselves, reported the existence of such a belief. In some such instances there was actually very little difference between disbelief and belief, in that both belief and disbelief are often supported by mention of specific cases (main report, pp. 92-93).

There are counterfactual cases, though few in number. These are of two types (main report, p. 93). The first type of counterfactual statement is that discontinuing a method helps a woman to conceive, not just restores the ability to conceive. The second type of counterfactual statement is that it is best for the health or welfare of the woman if she has babies as soon as possible.

⁴ Another woman expressed the same disbelief in another part of the interview.

The views of men were quite similar to those of women. Table 7 summarizes the views of all respondents. It can be seen that the major difference between male and female respondents is that there was only one case of a man stating that he had heard that the ability to conceive or deliver babies could be affected by method use, but did not believe it himself.

Table 7. Existence of Problems from Method Use Affecting Reproductive Capacity - Views of Women and Men		
Response category	Women	Men
Reproductive capacity can be impaired	48	38
Heard of problems, but disbelieves	17	1
Reproductive capacity cannot be impaired	75	73
Does not know	7	21
Other response	1	6
No response	2	2
Interviewed	150	141

In many cases there was a 'practical' aspect to the way in which responses were given by men (main report, p. 94), in which they deferred to the expertise behind the research and development of family planning methods or referred to the competence of staff within the family planning system. The existence of this 'practical' quality suggests that an approach to male involvement in family planning which exploits it could be fruitful. It is the way in which the validity of expertise is recognized that provides the hand-hold on which a successful male intervention could be built.

Apart from significant disincentives to the use of family planning methods before having children because of concerns about the effect of methods on reproductive capacity, some respondents disapprove of the use of methods on the related grounds that a woman should prove her reproductive capacity as soon as possible. Again there are distinct differences in the patterns of response given by men and women, with women less inclined to agree that it is necessary to prove their reproductive capacity.

Among women who do agree that it is necessary to prove their ability to have children, there are two distinct patterns. The first pattern subsumes all respondents who thought that they should have children to prove their reproductive capacity, but there are several different strands of response within this pattern (main report, pp. 95-96). Apart from the many women who feel they should endure a trial by ordeal to establish that they can bear children, another strand is the fear that using a family planning method will impair fecundability before reproductive capacity has been proved. A counterfactual strand is evident in the observation by some respondents that infertile women do not need to use methods, with the implication that unless fertility is established it might be unnecessary to use a family planning method.

The second pattern of response among women and men who thought that reproductive capacity should be proved was to say that it should be done by medical examination (main report, pp. 96-97). This pattern was very much less common among women than men. The

institution most commonly nominated for doing this is the 'hospital', by which is generally meant the Family Welfare Centre, and the most commonly nominated person is the 'doctor' meaning Family Welfare Visitor (FWV), who is not qualified to establish any such thing.

Especially among women, there were many who said that it was unnecessary to prove reproductive ability (main report, p. 97). Some respondents, but especially men, had difficulty giving any meaningful response on this topic, as shown in Table 8.

Table 8. Existence of Need to Prove Women's Reproductive Capacity - Views of Women and Men		
Response category	Women	Men
Reproductive capacity should be proved - by trial	43	32
- by 'doctor'	7	38
No need to prove reproductive capacity	77	33
Does not know, no opinion, unsure	9	18
Other response	7	13
No response	7	7
Interviewed	150	141

Nearly all respondents, both women and men, agreed that young married people had no problem with access to family planning methods. This consensus was based on the multiple avenues that existed to get hold of contraceptives. There were only thirteen cases in the sample where the woman was aged less than twenty years. Of these, only four had ever used methods other than 'traditional' methods, and they do refer to some minor problems of access (main report, pp. 98-99), such as unwillingness of older family members to allow visits of family planning workers, or the need for secret access through other relatives. It is reasonable to conclude that minor problems which do occur are easily overcome.

Despite the disincentives that we have discussed, 41 per cent of women and 30 per cent of men said that a method of family planning should be adopted before the birth of any children, as shown in Table 9. We suspect that approval of delaying the first birth could be even higher if respondents recognized that it was possible without jeopardizing reproductive capacity. For instance, out of the 86 women who said that at least one child should be born before a method was used, 28 mentioned concerns about loss of reproductive capacity as the reason, more than the number (24) who proffered any other single reason.

The evidence accumulated in this section indicates a very strong role for fear of loss of the capacity to bear children from the use of modern methods, the need to prove reproductive capacity, and the views of mothers-in-law, as motive forces to have children before adopting a method of family planning. It is reasonable to discount any major role for access to family planning methods.

Response category	Women	Men
None	61	42
One	16	26
One or two	16	33
Two	36	20
Two or three	10	6
One son and one daughter	2	-
Two to four	-	3
Three	3	3
Other number ^a	3	1
Other response	1	4
No response	2	3
Number interviewed	150	141

^a Includes one case of a man specifying 'one daughter and two sons', one case of a woman specifying 'three or four', one case of a woman specifying 'four' and one case of a woman specifying 'two sons and two daughters'

There are many other potential influences, such as socio-economic background, which should be taken into account in a more complete assessment. For this purpose, a multivariate analysis was carried out in the main report (pp. 103-105), using as dependent variable whether a woman said that family planning methods should be used before first birth or not. The explanatory variables included were religion, age of woman and man, education of woman and man, attitudes of parents-in-law, belief in effect on reproductive capacity by woman and man, views of woman and man on need to prove reproductive capacity, and whether each woman and man had heard of the safe period method, *azal* and condoms. Only two of these variables (the woman's belief in effect on reproductive capacity and her views about the need to prove reproductive capacity) were significant in a stepwise logistic regression analysis.

The model shows that if a woman believes that reproductive capacity can be impaired by the use of contraceptives and she also believes it is necessary to prove reproductive capacity by having a baby before using any method of family planning, the probability of agreeing that family planning can be used before the birth of a child is only about 8 per cent. At the other extreme, a woman who has neither of these beliefs is likely to say that family planning can be used before the birth of a child in 75 per cent of cases. This illustrates the extremely important role played by these self-reinforcing beliefs in determining use of family planning before first birth in Bangladesh.

Religiosity and method choice

There are at least two things to consider in assessing the influence of religious belief. The first concerns what Muslim respondents believe to be the views expressed by religious leaders on the sinfulness of family planning methods. There is not necessarily any

correlation between what they report the Mollahs to say and the respondents' own expressed views about the sinfulness or otherwise of family planning or particular methods. This is because, in Islam, the concept of sin is based in the believers' own opinions about what is right and wrong, and their own interpretation of scriptural evidence. The second factor to consider is a certain level of disjuncture between this personal concept of sin and actual behaviour.

Family planning service providers in Bangladesh have done much to neutralize opposition to the use of family planning by Islamic religious leaders. However, most of the interviews conducted as part of this study contained at least one reference to vehement opposition on the part of religious leaders to use of any or particular methods of family planning.

Many respondents refer to opposition to all methods of family planning by Islamic religious leaders (main report, pp. 109-110). However, if there is opposition in general, there must be a veritable campaign against sterilization, from the perception of ordinary respondents (main report, pp. 111-112). The two main aspects of what the Mollahs are believed to say are that the Mollahs will not give a proper religious burial to a woman who has had a tubal ligation or a man who has had a vasectomy, and that they will not take food from the hands of a sterilized person. There are also statements about prohibition of other methods, particularly abortion and use of IUDs, and evidence for a scale of sinfulness, with use of an IUD, sterilization and abortion (including menstrual regulation) in that order at the high end of an increasing scale. At the low end are the 'traditional' methods, condoms and hormonal methods. Some respondents seem to place the Mollahs' views about IUD use on the same level as restrictions on sterilization.

Statements about the Mollahs' views on abortion or menstrual regulation are rare, except as accompaniments to their reported views on permanent methods and IUDs, which have already been listed. This is basically because not only the Mollahs but the respondents regard abortion as so obviously sinful that the Mollahs do not need to remind people about it. When they are reported to have done so, the scale of the sin is easily assessed (main report, pp. 112-113).

Is the threat of withholding religious burial any more than just a threat? Some references to actual events were elicited (main report, p. 113), including one case where a man who had had a vasectomy could only be given a religious burial after a *moulavi* from a named neighbouring village agreed to do it. Enquiries by the interview team to the respondent and others elicited the additional information that the event referred to had taken place within the previous two years.

A substantial number of women referred to the hypocrisy of religious leaders who exhorted other people not to use family planning methods but used methods themselves. There were, among the respondents, a number of men who were religious leaders themselves, and some of them were aware of such criticism. Counter to the conventional wisdom, some respondents refer to far less strict views of their religious leaders, and it is noticeable that these respondents are often in close contact with the leaders whose views they report.

The important thing is not what the Mollahs actually say, but what people believe them to say. Even if all of the religious leaders, in the areas in which the study was conducted, were convinced that use of family planning methods is permissible in Islam, it would have little effect on the common perceptions unless they took positive steps to speak out in favour of family planning methods and did it loudly enough and often enough for all members of the society to know what they were saying.

Do people accept what they believe their religious leaders to say about family planning? We take a statistical approach to the issue by collating the number of references by respondents to their own beliefs in the sinfulness of all family planning methods or particular methods, deleting multiple references by individual respondents. The summary information in Table 10 is based only on the existence of definite statements by respondents about their beliefs. If they did not choose to include a statement about the sinfulness or otherwise of particular methods, then we cannot draw any conclusion about what their beliefs are. For example, the fact that many fewer men than women were inclined to make statements about the sinfulness or otherwise of the methods mentioned in the table might indicate no more than cultural difference between women and men in their way of making statements.

The extent of personal belief, on the part of women, that family planning methods are sinful is nevertheless striking. Men were far less inclined to make such statements. Without questioning the conviction with which these beliefs are held, when the beliefs were compared with current method use variables to determine whether there was any relationship, none was found.

Table 10. Perceived sinfulness of family planning methods, women and men		
Belief	Women	Men
All methods are sinful	88	17
Abortion is sinful	103	45
Sterilization is sinful	89	38
IUD use is sinful	24	10
Number of cases	150	141

Most of the information that has been discussed so far in this chapter came from discussion items where informants could choose for themselves whether they mentioned a particular matter or not. There was one issue which interviewers were asked to raise with respondents which was, by contrast, quite specific. This was whether the teachings of religion outweighed the needs of the family, in matters of family planning. From the tabulation of responses in Table 11, we conclude that the use of family planning methods is not influenced by religion for most respondents, either men or women. Among respondents, those who judge that religious instruction outweighs their families' needs contain many who feel anguish at the choices they have had to make, and a similar quality is present among many who have chosen to give priority to their families' needs (main report, pp. 116-119). Nevertheless, most respondents have been able to make a clear choice, in particular women.

In considering this question, many respondents gave as the basis for their choice that it would be a greater sin (than using family planning) to bring children into the world if they could not be fed, clothed and educated properly, or if there was not enough land for them.

Table 11. Religious teaching and the needs of the family		
Category of response	Women	Men
Family's needs outweigh religious teaching	116	75
Both family needs and religion are important	5	10
Religious teaching outweighs family's needs	11	13
No incompatibility between religion & family's needs	-	10
Nothing told by religion	3	18
Other response	12	10
No specific response	3	2
No response	-	3
Number of cases	150	141

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