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Intermittent Needs for Family Planning among Women with an Internal Migrant Husband in Bangladesh: A Qualitative Study

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Abstract: *Bangladesh is one of the major labour-exporting countries in the world, with large-scale labour migration flows occurring both internationally and domestically. Spousal separation due to migration has the potential to disrupt women's ability to use contraception in line with their reproductive goals. This qualitative study complements the 2014 Bangladesh Demographic and Health Survey (BDHS) data; we conducted in-depth interviews with a sub-sample of 23 BDHS respondents whose husbands stayed elsewhere but returned at least once a year to Barisal Division, Bangladesh. The study explores how husbands' migration patterns influence couples' fertility intentions, contraceptive decision-making and behaviour, and unintended pregnancies. Results showed that contraceptive use was high among the study participants, with nearly all couples using some method to avoid pregnancy – usually pills and condoms. However, the use was episodic and inconsistent, reducing effectiveness. Experiences of side effects were commonplace, which contributed to this pattern of inconsistent use: women used pills only during the duration of their husband's visits. Half of the informants experienced unintended pregnancies either due to the inconsistent use of pills or other method failures. The study findings indicate that women with migrant husbands need family planning education related to their particular circumstances and access to a wider range of family planning choices. Quality counselling should respect women's experiences with side effects and include thorough discussion of viable alternatives.* DOI: 10.1080/26410397.2022.2097044

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Introduction

Bangladesh has experienced a demographic transition marked by falling fertility rates and increasing contraceptive prevalence over the past several decades.[1] Over this same period Bangladesh has seen an equivalent transition in migration and urbanisation[2] and has become one of the major labour-exporting countries in the world.[3] Meanwhile, internal migration accounts for an estimated 66–90% of total migration in Bangladesh, predominantly composed of rural to urban migration.[4–8] National estimates indicate that 10% of the population have migrated in their lifetimes.[4,9]

Barisal, located in South-central Bangladesh, is particularly notable among Bangladesh's divisions for its rate of out-migration since the mid-1970s.[5,9] Major urban centres such as Dhaka, which owes much of its rapid growth to in-migration, are a primary destination.[2,4,10] Migrant labour is drawn to Dhaka by economic and livelihood prospects, especially in the ready-made garment, transportation, and other manufacturing sectors.[2,4,8,11–13] An extensive water transport system facilitates migration routes back and forth between Barisal and Dhaka.[5,14,15]

Internal migration is highly skewed toward male labour.[5,8,9] Estimates that upwards of two-thirds of internal migrants are married [9] produce a high probability of spousal separation. Neelim and Siddiqui [5] suggest that this results in a disproportionate percentage of left-behind families that

are female-headed households. However, the longstanding norm of extended households, where the spouses typically live with the husband's parent/s and siblings, may moderate this impact somewhat.[1,16,17]

Undoubtedly, such levels of internal migration shape and reshape the lives of both migrants and families left behind. Much of the research on impacts on left-behind families has focused on remittances and poverty-reducing effects.[2,4,8,18] Less is known about impacts of internal migration on reproductive behaviours.[19] The conditions of families left behind, particularly in terms of their health, are among the research gaps identified by the International Organization for Migration (IOM).[5]

Spousal separation may be sufficient to suppress aggregate levels of fertility and affect contraceptive behaviours.[20–23] Recent analysis in Nepal indicates male migration and associated spousal separation is the most important factor explaining the decline in fertility.[24,25] In Southern Mozambique women married to migrants had a lower birth rate [26] and men's out-migration has been associated with reduced contraceptive use in multiple studies elsewhere in South Asia.[21,27–29] Much of the existing empirical evidence we have on the fertility-related behaviours of women married to men who migrate come from a context defined by long-term, international migration.

Impacts may differ if men's labour migration is internal migration with frequent return visits, as exists between Barisal and Dhaka. Evidence in Bangladesh is not consistent. For example, one study suggests that prolonged migration of husbands may reduce fertility by delaying the first birth[30] while another suggests it may hasten the first birth.[31]

Spousal separation due to migration often implies an absence of sexual activity but this may not be the case for women whose migrant husbands return home for periodic visits. Ban et al[21] caution that while the risk of pregnancy may be reduced during separations, "One cannot assume that a couple has no risk of unintended pregnancy", particularly if husbands' visits are unexpected. Such women may have a pattern of sexual intercourse with their husbands that is sporadic and episodic. These women may have different contraceptive needs than either women with cohabiting husbands or women with long-term migrant husbands. They may desire contraceptive methods which accommodate the absence-and-return-visit migration patterns of their husbands.

Migration of husbands may also influence women's ability to access contraception, even if appropriate methods are readily available. With the husband's absence from the home, the husband's parents in extended households may act as his surrogate in controlling the movements of his wife, with mobility restrictions and care responsibilities leading to wives being closely tied to the household.[31] Women who are themselves migrants have been shown to use reproductive health services less often than non-migrant women, but less is known about such care-seeking among women married to internal migrants.

Given the potential for internal migration to influence fertility and contraceptive behaviour, this study addresses gaps in what is known about the fertility intentions of women with husbands who live elsewhere in Bangladesh, how they perceive and manage their risk of pregnancy, and how they respond to unintended pregnancy. Specifically, it is unknown whether women have a reduced need for contraceptive services because of less coital frequency and reduced risk of pregnancy, or whether they have more complex needs for family planning, by virtue of the intermittent presence of their husbands. This study uses qualitative interviews with a subset of women completing the 2014 Bangladesh Demographic and Health Survey (BDHS) to investigate how women with internal migrant husbands understand and manage their risk of getting pregnant in Barisal Division, Bangladesh.

Methods

Study site, sampling, and data collection

This study was conducted between September 2014 and February 2015, using a sub-sample of women covered in the BDHS 2014. According to the latest data, approximately 17% of currently married women aged 15–49 in Bangladesh have a husband who lives elsewhere.[1] Barisal Division has the second highest percentage of women with migrant husbands (22%), with rates higher in rural areas than in urban areas. Approximately 80% of migrant husbands return to the household at least once a year in Barisal, exceeding the national average return rate for migrant husbands (57%). Contraceptive use among this group of women lags behind by 24 percentage points

compared to the population of all women aged 15–49 years (authors' calculations).

Data were collected in eight selected BDHS rural clusters in two of six districts of Barisal Division, namely Barisal and Patuakhali. These districts were selected due to their proximity and accessibility for the research team and for the high concentration of eligible women (7.6 eligible women per cluster on average compared to 3.3 eligible women per cluster for Barisal Division). The study participants were selected using the following criteria: (1) currently married women aged 15–49, (2) whose husbands lived elsewhere but made at least one visit in the last 12 months, and (3) who did not want any more children or wanted to delay birth at least for two years. Accordingly, 23 women from a list of 61 surveyed women in study clusters were selected as participants. These women were all eligible according to the selection criteria and had indicated their interest in and consented to participating in the study during their interview for the main BDHS survey.

The qualitative interviews could be linked with limited quantitative data from the BDHS survey on migration (e.g. number of husband's visits to home in the past 12 months) and contraceptive use (e.g. current method and contraceptive history in the past 5 years). The qualitative interviews supplemented these data with in-depth enquiry into migration patterns, such as husband's occupation; distances, frequency, and duration of return visits; impetus of return visits; and the extent to which they were pre-arranged as well as the pattern of contraceptive experiences, goals, and attitudes over the full period during which the husband was an internal migrant. Although predominantly qualitative in nature, some of these details could be tabulated for the sample of respondents.

Our qualitative investigation entailed in-depth, open-ended interviews with the study participants which took place in the weeks following the interview for the BDHS quantitative survey. A flexible interview guide prompted women to reflect on their lives in general and their reproductive health in particular. The discussions were facilitated to understand the strategies women used to manage their reproductive goals, the barriers and facilitating factors in accessing family planning methods, their knowledge of effective contraceptive use, and their experiences, perceptions, and attitudes surrounding unintended pregnancies and the outcome of unintended pregnancies.

The study team included nine members. Four researchers with master's degrees in anthropology were involved in data collection, data editing, transcription, translation of the transcripts, and coding and analysing the data. One field assistant assisted the field research team in locating and contacting eligible participants in the field. Three principal investigators and one co-investigator led the data analysis and report writing.

Ethical considerations

Ethical clearance for the study was obtained from the Ethical Review Committee (ERC) of icddr,b, on 24th September 2014 and ICF's Institutional Review Board (IRB) on 30th September 2014. Before conducting the interviews, the objectives of the study were conveyed to the women who gave written consent and were assured of their right to dissolve the interviews at any point. The interviews lasted one to two hours and were carried out in the women's houses in a place where privacy could be assured.

Data management and analysis

All interviews were recorded and later transcribed verbatim (in Bangla). Following data collection, the research team developed a coding system, capturing the main research themes and concepts generated from the data. Interviews were coded in Atlas.ti. The authors developed a matrix analysis framework and organised the codes under the broader objectives of the study. Data were triangulated to assess the validity (meaningfulness) and reliability (consistency) of the data and only those concepts that could be validated were retained. Along with these, SPSS and Stata were used to analyse the socio-economic background of the participants.

Results

Socio-economic background

The mean age of the study participants was 28 years and they were married for an average of 16 years (Table 1). Their husbands, with an average age of 36, were almost 8 years older than them. Compared to their husbands, the study participants had less education and all were housewives at the time of the interview. A little less than half of the husbands were service holders in various government, private, and non-government organisations. The remaining husbands were involved in different types of income-generating activities, which

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

Variables	($n = 23$)
Women's age in years (mean and range)	28 (18–40)
Women's age in years at marriage (mean and range)	16 (12–21)
Women's years of schooling	
0 years	2
1–5 years	4
6–10 years	13
12 + years	4
Women's occupation	
Housewife	23
Other	0
Husband's age in years (mean and range)	36 (21–55)
Husband's years of schooling	
0 years	1
1–5 years	5
6–10 years	11
12 + years	6
Husband's occupation	
Service holder (Govt., NGO & private)	10
Van/CNG/car driver	4
Day labourer	3
RMG worker	2
Salesmen	2
Driver (Launch)	1
Contractor	1
Mean duration (years) of work outside the home	13 (2–30)
Mean duration (years) of marriage	11 (1.5–26)
Number of home visits by husband in the past year	
1–2 times	1
3–4 times	7
5–6 times	6
7–8 times	3
8 + times	6
Family type	
Nuclear	10
Extended[a]	13
Parity (mean and range)	2.05 (1–3)
Desired number of children (mean and range)	2.26 (2–3)

[a]Where spouses typically live with the husband's parent/s and siblings.

included ready-made garment (RMG) workers and drivers of different types of vehicles. Most of the women (15 of 23) were living with their parents-in-law and husbands' siblings. The remaining eight women lived in a nuclear setting with their children. On average, the study participants had two children and the mean desired number of children of the couple was 2.26.

Most of the husbands (16 of 23) migrated away from their home village before marriage while close to one-third migrated after a few years of marriage. The average duration of their working away from home was 13 years (with a range of 3 years to 30 years). Almost all the men worked in Dhaka or peri-urban areas near Dhaka, nearly 123 and 176 km away from their hometowns of Barisal and Patuakhali, respectively. A few men worked in the same district as their hometown and resided near their workstations. Respondents reported that close proximity and cheap accessible water-based transportation made it easier for these men to visit their families regularly. More than half of the men visited their families three to six times during the past year while one-fourth made more than eight visits. They spent one to seven days per visit with their families. This migration pattern varied little by men's occupation or distance to workplace.

The general pattern of spousal visits consisted of men returning to their families' home. Very occasionally, some women made short visits to their husbands. Such visits occurred particularly when they needed better quality health facilities, available in the cities where their husbands worked. Most men shared accommodations with other male colleagues or relatives, which deterred women from making frequent and long visits to their husbands.

Women's contraception experiences

All the women in our sample used contraception at some point during their marriages. Almost half of the women (12 of 23) first started using contraception upon marriage. The remaining half (11 of 23) did not adopt any contraception until after they had their first baby.

Table 2 shows women's history of family planning method use, grouped by the duration of marriage. Most of the women had experience with more than one method, which included modern methods as well as traditional and herbal methods. Table 2 also suggests that long-term method use (namely Norplant use) was low and concentrated among older women who were married for 10–20 years. Traditional methods were also very common among women married for 10–20 years. Interestingly, the pattern of use of multiple methods did not vary with years of marriage. Many women also had intermittent spells when they did not use any method and two women relied on lactational amenorrhoea during a period of time following birth.

Women's selections of methods were made taking into consideration the context of their husband's migrant status. Pills figured prominently, followed by condoms and injectables. Women viewed traditional methods to be risky and used them only as a last resort. This included those instances when another method was not readily available at home or when they had stopped using pills or other methods due to experiencing side effects. Women disliked implants due to their side effects and viewed IUDs and permanent methods as undesirable because they were particularly invasive.

Pills

Table 2 shows that almost all women (21) used the pill at some point in their lives while five exclusively used this method. Most women considered the pill to be an appropriate method for a couple to use when their husband lives elsewhere and visits them occasionally and to be more appropriate than long-term methods. One woman explained her preference for pills by comparing them to injectables and said,

"*Every method is good. No method is bad. But you have to choose the one that suits on you. And I do not need those injections for 3 or 9 months duration. Why should I take that injection as he does not stay at home?*" (29-year-old woman whose husband has been a migrant for 20 years)

Women obtained pills from various government and non-governmental health facilities in and around the community and from community health workers associated with these facilities. Most women said that they usually do not get or ask for any relevant instructions on how to use the pill. Women/couples learned how to use the pill from other pill users or from the instructions written on the packet. Most women knew how to take make-up pills when pills were missed for one or two days in the cycle. Women were by and large very conscientious about missed pills in order to avoid the risk of pregnancy.

The women whose husbands became migrant workers after a few years of marriage, said that they used to take the pill regularly on a daily basis when they lived together. However, once their husbands migrated for work, they modified their pill use to take pills only during the time when their husbands visited them. One woman said,

"*Because my husband doesn't live with me all the time, I can take it for 2 or 3 days only and I feel fine for having it for a short time. So, I prefer pill.*" (31-year-old woman whose husband has been a migrant for 5 years)

The same woman who earlier preferred pills to injectables explained her rationale for taking pills in this manner,

"*I have my own way of taking contraception, like you have yours. You should take method continuously when your husband lives with you and I should not take pill every day as my husband lives apart. Why should I take those pills unnecessarily? I should take pills only those days when my husband is here … Taking of two or three pills serves my purpose when he stayed at home. I know everything [referring to usual instructions] but do not take those as they are not applicable*

Table 2. Women's method use and reproductive history, by duration of marriage (N = 23)

Years of marriage Method(s) used[a]	Number of women				Number of pregnancies[b]	
	1–5 Y (n = 6)	6–10 Y (n = 5)	10–20 Y (n = 12)	Total (N = 23)	Unintended pregnancy	Pregnancy termination
Pill+ Condom	2	–	–	2	2	1
Pill+ Condom+ Withdrawal	1	–	–	1	–	–
Pill+ Abstinence	1	–	–	1	1	–
Condom	1	–	–	1	1	–
Pill	1	1	3	5	2	–
Pill+ Condom+ Abstinence	–	1	–	1	1	–
Pill+ Injection+ LAM	–	1	–	1	1	–
Pill+ Injection	–	1	2	3	1	–
Pill+ Condom+ Injection+ LAM	–	1	1	2	1	1
Pill+ Injection+ Norplant	–	–	1	1	2	–
Pill+ Condom+ Injection+ Norplant+ Withdrawal + Abstinence	–	–	1	1	4	2
Pill+ Condom+ Withdrawal+ Abstinence	–	–	1	1	–	–
Pill+ Injection+ Herbal	–	–	1	1	1	–
Pill+ Injection+ Abstinence	–	–	1	1	1	–
Condom+ Injection+ Withdrawal	–	–	1	1	1	1
Total	**6**	**5**	**12**	**23**	**19**	**5**

[a]Denotes methods used over women's lifetimes and not the sequence in which methods were used.
[b]In total, 14 women experienced a total of 19 unintended pregnancies.

for me. I only use that which I need." (29-year-old woman whose husband has been a migrant for 20 years)

Women found it cumbersome to take the pill on a daily basis. Because women perceived no additional benefit of taking the pill daily when the husband is not around, they developed their own strategy of intermittent pill use coordinated around their husbands' visits. This strategy was often endorsed by the older pill users with migrant husbands and most importantly, by community health workers.

Some women extended use by taking pills for a couple more days after their husbands' departure in an attempt to be extra cautious. This woman said,

"*She (health worker) told to take the pill just before doing intercourse and continue it for extra two days after his departure.*" (29-year-old woman whose husband has been a migrant for 14 years)

Thirteen of the 21 pill users experienced various side effects and many women cited that regular use of pills for the entire month makes them more susceptible to headaches, body aches, dizziness, vomiting, and other side effects, which were often very severe and interfered with their daily activities. They were less exposed to such side effects when they used the pill only for a few days. The desire to minimise side effects, combined with their perception of reduced need while husbands were away, reinforced women's pattern of intermittent pill use around husbands' visits. One woman in this respect said,

"*The rule is to take the pill for the entire month after having the period. But I do not take it for the full month. It develops head spinning for me which I cannot tolerate. So I take it only when he stays at home. I discontinue it when he leaves. I cannot take it for the whole month.*" (22-year-old woman whose husband has been a migrant for 12 years)

Injectables

Table 2 shows that a little less than half of the women (11 of 23) reported using injectables at some point in their lives. Women usually used injectables only after having one or two children. Women in this study reiterated a common belief in the community that injectables could make a woman infertile and hence women used it only for a short duration and intermittently.

Women generally obtain injectables from a health facility, which was often inconvenient for them as it often incorporated travelling. There were mixed feelings about injectables being an appropriate method for women with migrant husbands. Some considered it an appropriate method because it offered worry-free protection for several months when visits may be erratic, as this woman said:

"*I think women with migrating husbands should use injectables. At times, contraceptives (pills or condoms) may not be available at home and it is a risk when husband gives sudden visits. In such case, injectables keep you risk-free.*" (35-year-old woman whose husband has been a migrant for 18 years)

On the other hand, some women thought that injectables would only be appropriate when the couple lives together regularly. Three women whose husbands began migrating several years after they married stopped using injectables and switched to the pill for this reason. As one woman said,

"*Do I need to take injectable? He does not come home for three or four months. When he stays, pill does it for me.*" (24-year-old woman whose husband has been a migrant for 10 years)

Condoms

A little less than half of the women (10 of 23 couples) used condoms some time in their lifetime and the majority of those who used condoms also used another method at some other point in their reproductive history, namely pills or traditional methods. Condom use was more common among young couples than among older ones. Condoms were considered to be an appropriate method for couples in which the husband is a migrant, particularly in those situations when it was not possible to acquire pills for a particular visit or when visits occurred on short notice. Just as women viewed condoms as a back-up method to pill use, women viewed traditional methods (namely, withdrawal and periodic abstinence ("safe period") as a back-up method to combine with condoms. Women appreciated condoms for being one method having no side effects or consequences on women's health. This woman said,

"*So I think pills or condoms are good. Pills make head spinning. But condoms are without any risk. It is to be used on the spot and finished on the spot. There are no difficulties in that.*" (35-year-old woman whose husband has been a migrant for 21 years)

Husbands' involvement

Men were usually willing and cooperative partners in women's contraceptive use. Most women said that they themselves took the decisions in terms of what method to use and when to use it and informed their husbands of their decisions. They reported their husbands seldom disagreed. On the other hand, some women started using contraception without informing their husbands, out of fear that they would oppose it. In most of these cases, these husbands also became supportive when they later learned about their wives' contraceptive use. As this woman said,

"*I didn't seek permission, I informed him later. He didn't say anything. Actually he is always very*

supportive (to avoid unwanted pregnancy). He said it would be problematic to have another child when the first one is still very young." (29-year-old woman whose husband has been a migrant for 14 years)

Husbands supported their wives in terms of reminding them to take pills, buying contraception (condoms or pills) and bringing it with them on their way home when needed, using condoms and withdrawal, by planning their visits to coincide with their wives' safe period, or consulting with physicians regarding the side effects their wives were experiencing.

With the ubiquitous use of mobile phones, women reported that their husbands planned their return visits with them in advance and therefore, sudden, surprise visits rarely occurred. Women whose husbands have a long history of migration recalled earlier times when mobile phones were not available and prior communication was difficult and, therefore, their husbands' visits had been often sudden and unexpected. In these earlier days, some husbands used to inform them of their plans through other migrating relatives and neighbours. However, this process was not conducive to timely or reciprocal communication and impeded preparations, including obtaining contraception, prior to the husband's visit.

In contrast to the earlier times when regular communication was hard, spouses now openly discussed their family planning needs over the mobile phone along with other things related to the family and children's affairs. They discussed if contraception would be available at home or not, what methods they should use during the upcoming visit, whether women would be in their *safe period* of their cycle during the visit, and who is going to take the responsibility of managing the contraceptive methods. One woman said,

"*I inform him over mobile phone. I tell him not to come if I have had my period. I also tell him the date when it ends, accordingly he manages leaves from workplace. It is now the time of mobile phone, not the era of written letters.*" (22-year-old woman whose husband has been a migrant for 8 years)

Another woman said,

"*We talk over mobile phone and he always informs me before coming to home. And I tell him to bring the method. Again, when he comes without informing, I tell him to bring it when he usually visits the nearby market at evening.*" (28-year-old woman whose husband has been a migrant for 9 years)

Women said that when they were on the pill, couples discussed prior to the visits over the phone the availability of pills at home and who and from where they would obtain the pills. Often, husbands brought pills for their wives when they came to visit. If both spouses failed to get pills prior to the visits, women would get them from neighbours, sometimes borrowing a full pack and sometimes borrowing just a few pills from the neighbour's pack.

Condom users noted that condoms are available all the time in the shop and their husbands could easily pick them up during their travel home, even on impromptu visits, as their route frequently passes through areas with such shops. In fact, it was mostly the husbands who obtained condoms as, unlike other methods, women felt uncomfortable doing so. Many women also reported that keeping or storing condoms at home is a hassle and a source of embarrassment if others, including grown children, daughters-in-law, or other family members see them. Therefore, women want their husbands to obtain condoms only for a particular visit. Husbands played a very supportive role in terms of bringing condoms home with them, owing in part to the convenience of purchasing them on their way home. One woman said,

"*No, no, no, are you crazy! How could I purchase it from a shop? How could a woman do that? Isn't it a matter of shame?*" (40-year-old woman whose husband has been a migrant for 12 years)

Husbands were also involved in managing side effects, if women experienced them. When women faced side effects, women and their husbands decided together to switch to another method and most women switching methods remained continuously protected from pregnancy due to their husband's supportive participation. This woman said,

"*So I told him about my sickness (side-effects due to taking pill) and he told me that I will be fine since he will be going to Dhaka and will not visit me for a long time. So it was not a problem for me (to not use a pill for a while).*" (31-year-old woman whose husband has been a migrant for 5 years)

Many pill users, while facing side effects, had discussions with their husbands about trying another method and their husbands were in full agreement with them. At least three husbands offered to use condoms and used them for a while. While some husbands asked their wives to switch to another brand of pills, many husbands prevented women from using other methods which they heard cause severe side effects. Both women who used Norplant decided along with their husbands to take out the implant due to experiencing severe bleeding. However, both women had an unintended pregnancy shortly after the removal. This was because their husbands were at home during this period and there was a delay in deciding on the next method to use.

Unintended pregnancy

Most couples worked cooperatively to plan their desired family size and birth spacing, as well as avoiding unintended pregnancies. However, this planning did not often translate into reality. A little more than half of the women (14 of 23) experienced unintended pregnancy, including eight women whose first pregnancies were mistimed and three women who had multiple unintended pregnancies. Further, eight of the 14 women had unwanted pregnancies after they said they had already completed their desired family size. Interestingly, younger couples encountered unintended pregnancies as much as the older couples.

Most women said that they did not know the reason how they got pregnant when they were using contraception, as this woman said,

"*Actually, he was using condom, however, I conceived. I don't know why it happened.*" (24-year-old woman whose husband has been a migrant for 8 years)

Some women thought that they had missed pills during their husbands' short stay or miscalculated their safe period. A few who used less effective, traditional methods described method failure or missing the time their next injectable was due. Interestingly, women who were using pills only during husband's returns did not attribute pregnancy to their intermittent use of the pill. They thought they were protected. This woman said,

"*I was taking pills. I do not know what happened, I might have missed somehow.*" (39-year-old woman whose husband has been a migrant for 21 years)

As Table 2 indicated, these 14 women experienced 19 unwanted or mistimed pregnancies. While women were the lead decision-makers in using contraception, the decision surrounding how to handle an unintended pregnancy was influenced by husbands, family, and the general sentiment in the broader community. Women said that pregnancy termination is usually perceived as "sin", socially stigmatised, and unacceptable. General community perception including among health care providers, as expressed by the study participants, is that a pregnancy termination may make a woman infertile or have a toll on her health, particularly when it is the first pregnancy. While either women, their husbands, or both considered terminating the pregnancy, 14 of the 19 unintended pregnancies were continued to term* for these reasons. In 8 of these 14 instances, women and their husbands decided together to continue the pregnancy while women took the decision to continue the pregnancy in four instances. However, in two instances, women who wanted to terminate continued the pregnancy because their husbands disagreed. One woman said,

"*I decided to go for pregnancy termination. I didn't have the desire to take any more children. But my husband didn't agree. Elders also suggested to continue the pregnancy. It was during the 2nd month of pregnancy when I myself went for it (termination), however, the doctor said he wouldn't do it without my husband's consent.*" (35-year-old woman whose husband has been a migrant for 18 years)

The remaining five of the 19 unintended pregnancies were terminated. As with the decision to continue an unintended pregnancy, in the majority of instances (three), both spouses decided together to terminate the pregnancy. In the other two

*In Bangladesh, induced abortion is illegal except to save a pregnant person's life according to the Penal Code of 1860. However, menstrual regulation (MR) is permitted up to 12 weeks following the last menstrual period and is offered through the government's family planning programme. [31] MR is a manual vacuum aspiration procedure or use of medication (misoprostol or mifepristone plus misoprostol) to induce menstruation after it has been absent for a short period of time, often without definitive confirmation of pregnancy. In this study, we did not ascertain the procedure or time since last menstrual period of any such procedures.

instances, either the woman or husband led the decision. These couples did not want a child just after marriage or soon after a previous birth because they thought that getting pregnant at that time would be harmful to both the mother and the children (both the newborn and the older child) or for their family's poor economic condition. These concerns outweighed negative attitudes toward termination. This woman said,

"*My husband agreed with the decision but everyone advised me to keep it because none of them had children in the family. I did it because of my baby's health and my health. At some point my husband was also puzzled about what to do. Then I took the final decision and he agreed.*" (24 year-old woman whose husband had been a migrant for 10 years)

In total, only nine women were able to successfully plan their births and use contraception effectively to prevent unintended pregnancies.

Discussion

A longstanding notion in demographic literature is that of "absent and problematic men".[32] Although *physically* absent for stretches of time, the men referred to in our study confounded this narrative. In contrast to conventional wisdom, the women's migrant husbands were communicative, agreeable, and collaborative partners in their wives' reproductive goals. They supported their wives' choices to use contraception, took the lead in these decisions, and helped them decide on specific contraceptive methods. Husbands acquired contraception, strategised with their wives on how to manage side effects, and actively participated in using condoms or traditional methods at times that it was needed. For the four women who terminated unintended pregnancies, they were important allies in the face of other family members who disagreed with their decisions. This finding suggests concerns about male domination in terms of familial decision-making[33–35] or diminished autonomous decision-making capacity of women living with their in-laws[31,36] may not be fully realised in this particular setting. It is also an encouraging finding for those in the family planning field who have been working towards greater gender equality and positive male engagement.

While the general pattern was one of cooperative decision-making, agreement and support were not universal, as the case of at least one woman whose husband's disapproval interfered with her ability to terminate a pregnancy attests. Further, in several instances, husbands dissuaded their wives from switching to specific contraceptive methods, out of a desire to protect them from experiencing further side effects. A more notable negative side to migrant husbands' active participation may be that their role as buyers and bringers of contraception facilitated women's incorrect pattern of pill use, taking pills only on the days around and during their husbands' visits. These findings suggest that more effort is still needed to reach married men as well as women with accurate, detailed information about contraceptive methods and to continue promoting balanced decision-making, as the goals of gender equality and positive male engagement are not complete.

Unexpected visits did not contribute much to the risk of unintended pregnancy. Husbands' visits are well planned, with anticipation of sexual intercourse and preparation for contraceptive use being key components. This planning is facilitated by the ubiquitous use of mobile phones. This finding is in line with the findings of other studies regarding the potential for mobile phone use to deepen already strong ties (as exist between spouses) in the presence of migration in Bangladesh.[37]

The contraceptive methods women with migrant husbands used in this study are not dissimilar from that of the general population of women. Pills (25%), injectables (11%), and condoms (7%) are the most common contraceptive methods in Bangladesh (NIPORT and ICF 2020). Longer-term methods like Copper-T, IUDs and implants and permanent methods were not preferred because women deemed them to be invasive, a finding consistent with existing studies.[38–41] The greater popularity of condoms among younger couples is also consistent with other studies of the general population. [42–45] This suggests that broader community norms and attitudes about methods influenced our study population's preferences. Nonetheless, the women in our study clearly reported that their method selection was shaped by considerations of their husbands' internal migration patterns.

Women with migrant husbands have been found in other studies in South Asia to time their contraceptive use around their husbands' schedules,[28] although these studies involved a

different pattern of international migration with longer cycles of out-migration and return visits. The women in these other studies cited rumours and gossip (around infidelity) as motivation for episodic contraceptive use. This rationale did not emerge in our study population. Women in our study cited more practical considerations of convenience, saying plainly that continuous contraceptive use was "not needed".

Perhaps the most striking finding in this study is the widespread pattern of incorrect pill use tailored to their husbands' internal migration pattern: women with internal migrant husbands did not complete packets, taking pills only during visits. This contributed to common experiences of unintended pregnancies, though women did not believe themselves to be at risk of such.

In general, lack of knowledge of how contraceptive methods work is at the very heart of experiencing unintended pregnancies.[46–49] In this case, it is not a lack of general knowledge but specifically of how to correctly apply that knowledge to their particular circumstances as wives of internal migrant husbands that places them at increased risk.

Although they have good contraceptive knowledge by traditional measures, the women in our study neither sought nor received instructions on how to take the pill correctly given their particular circumstances. This suggests that health providers should be more proactive in supplying such information. It may behove health workers in areas with high migration, such as Barisal and Chittagong (now Chattogram) Divisions, to screen family planning clients for their migration context so that they can customise advice to their individual circumstances. Information about the importance of taking complete packets of pills should be disseminated broadly through multiple media, because providers are not the only source of guidance for women with migrant husbands. Their families, husbands, and neighbours figure prominently in this study.

The experience of side effects (of pill, injectable, and implant users) was substantial among women in this study. Side effects are a common reason for contraceptive discontinuation and method switching.[38,39,50–52] In this study, side effects further fuelled incorrect pill use by women with internal migrant husbands.

Women with internal migrant husbands are unnecessarily put at risk of unintended pregnancy. Women in this study had multiple factors that should minimise this risk: few barriers to accessing contraception, supportive husbands, and social networks in the community. However, this is undermined by this pattern of pill use tailored to their husbands' migration patterns and designed to minimise side effects.

Women's concerns with side effects, which are sometimes debilitating, need to be taken seriously. This requires that health providers (at all levels) listen to women and expand contraceptive counselling to more fully address side effects, including working with women collaboratively to find the specific method that works for them. However, this is not a matter to be solved by improved client-provider interactions alone. Facilities will need to have a fully stocked inventory to offer women a variety of methods, including more than one formulation of the contraceptive pill. In consideration of women's concerns, experiences, and general health status, global investments in development of new and improved contraceptive technologies should be undertaken specifically with minimising side effects in mind. This has implications for the health system as a whole, from the facility level through to the policy level and at each stage of the supply chain. Such improvements would have benefits for all women, but especially for those with migrant husbands.

Limitations

This study applied qualitative techniques allowing the researchers to investigate deeply the lives of an understudied population: women married to internal migrant husbands. Additionally, the study was embedded in a larger, quantitative survey and could draw on broad contextual data in the BDHS. In spite of these strengths, the study has several limitations to note. First, because our sample comprised only women with internal migrant husbands, we are limited in our ability to compare women in our study to those with non-migrant husbands or the general population of women. Second, data for this study were collected several years ago and it is possible that circumstances have changed over time for women with internal migrant husbands. We believe that our findings remain relevant for three reasons: first, there was remarkable consistency in the study themes over the course of women's (sometimes long) life experience with migrant husbands; and second, there have only been modest shifts in contraceptive behaviour in

Bangladesh since the time of this study. Additionally, the percentage of women in Barisal division with an internal migrant husband has only increased since the study period,[1] making our study results even more salient to a larger population. Third, we can reasonably conclude the themes in our study would be broadly comparable to women elsewhere in Bangladesh with migrant husbands who return frequently throughout the year. This is particularly so for women occupying a similar socio-economic and cultural milieu. However, we cannot generalise our findings to other locales or populations marked by fundamentally different migration patterns, such as long-term or international migration in which return visits are infrequent, or to women migrants. Nonetheless, this study makes a valuable contribution to a sparse literature on the reproductive health needs of women with periodically absent husbands.

Conclusion

This study sheds light on an oft-overlooked topic: the family planning needs and practices of women with temporarily migrant husbands. We find that internal migrant husbands are not impediments, but rather cooperative partners who facilitate their wives' use of contraception. However, the intermittent nature of husbands' migration patterns, experience of side effects, and misinformation about how their chosen method works all lead women with internal migrant husbands to develop a pattern of pill use that fails to protect them adequately from the risk of unintended pregnancy. This study's findings lead to recommendations for reproductive health services to advance contraceptive education, increase method choice, and for health workers to improve client counselling.

Disclosure statement

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Author's contributions

1. Rasheda Khan, the first author and the corresponding author of this paper, was one of the co-principal investigators of the research project and was involved in conceptualising the study, developing the research protocol including the research design and getting clearance from the Research Review Committee (RRC) and Ethical Review Committee (ERC) from icddr,b. She was also responsible for leading the data analysis and interpretation of the data for this paper. She developed the first draft of the paper and incorporated feedbacks from other co-authors.
2. Kerry L.D. MacQuarrie, the second author of the paper was another co-principal investigator of the research project and was involved in conceptualising the study, developing the research protocol including the research design and getting clearance from the Research Review Committee (RRC) and Ethical Review Committee (ERC) from ICF. She was also involved in analysing and interpreting the data. She was heavily involved in critically reviewing and editing the paper.
3. Marzia Sultana, the third author of the paper, was a co-investigator of the research project and was responsible in analysing and interpreting the data, and reviewing and incorporating feedback from other authors of the paper.
4. Quamrun Nahar, the fourth author and the senior author of the paper, was the principal investigator of the research project and was responsible for conceptualising the study, developing the research protocol including the research design and getting clearance from Research Review Committee (RRC) and Ethical Review Committee (ERC) from icddr,b. She was also involved in analysing and interpreting the data. She critically reviewed the paper and provided feedback to the paper. She is also responsible for the final approval of the paper at the institutional level.

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Résumé

Le Bangladesh est l'un des principaux pays exportateurs de main-d'œuvre dans le monde, avec de vastes flux migratoires de travailleurs qui se produisent aussi bien au niveau international qu'à l'intérieur des frontières nationales du pays. La séparation des conjoints en raison de la migration a le potentiel de saper la capacité des femmes à utiliser une contraception conformément à leurs objectifs de procréation. Cette étude complète les données de l'enquête démographique et de santé (EDS) du Bangladesh de 2014; nous avons mené des entretiens approfondis avec un sous-échantillon de 23 répondantes à l'EDS dont le mari vivait ailleurs, mais qui revenait au moins une fois par an dans la Division de Barisal, Bangladesh. L'étude se demande comment les modes migratoires des époux influencent les intentions de fécondité des couples, leur prise de décision et leur comportement en matière de contraception et les grossesses non désirées. Les résultats ont montré que l'emploi de contraceptifs était élevé parmi les participantes à l'étude, presque tous les couples utilisant une méthode pour éviter les grossesses, habituellement la pilule et le préservatif. Néanmoins, l'utilisation était épisodique et irrégulière, ce qui en réduisait l'efficacité. Les antécédents d'effets secondaires étaient fréquents, ce qui contribuait à ce mode d'utilisation irrégulière: les femmes utilisaient la pilule uniquement pendant la durée de la visite de leur mari. La moitié des informatrices ont eu des grossesses non désirées soit en raison de la prise irrégulière de la pilule soit du fait de l'échec d'une autre méthode. Les conclusions de l'étude indiquent que les femmes mariées à des migrants ont besoin d'une information sur la planification familiale relative à leurs circonstances particulières et doivent avoir accès à un éventail élargi de méthodes de planification familiale. Des conseils de qualité doivent respecter le ressenti des femmes quant aux effets secondaires et inclure une discussion détaillée des options viables.

Resumen

Bangladés es uno de los principales países exportadores de mano de obra en el mundo, con flujos migratorios laborales en gran escala ocurriendo internacional y nacionalmente. La separación conyugal por migración tiene el potencial de interrumpir la capacidad de las mujeres para utilizar anticoncepción en consonancia con sus metas reproductivas. Este estudio complementa los datos de la Encuesta Demográfica y de Salud (ENDESAB) de 2014 de Bangladés; realizamos entrevistas a profundidad con una submuestra de 23 personas encuestadas cuyos esposos se quedaban en otro lugar, pero regresaban como mínimo una vez al año en la División de Barisal, Bangladés. El estudio explora cómo los patrones de migración de los esposos influyen en las intenciones de fertilidad de las parejas, en su toma de decisiones y comportamientos relacionados con la anticoncepción y en los embarazos no intencionales. Los resultados mostraron un alto uso de anticonceptivos entre participantes del estudio; casi todas las parejas usaban algún método para evitar el embarazo, usualmente píldoras y condones. Sin embargo, el uso era episódico y no sistemático, lo cual reduce la eficacia. Las experiencias de efectos secundarios eran comunes, lo cual contribuyó al patrón de uso no sistemático: las mujeres usaban píldoras solo durante la visita de su esposo. La mitad de las informantes tuvieron embarazos no intencionales, ya sea debido al uso no sistemático de las píldoras o debido a otra falla del método. Los hallazgos del estudio indican que las mujeres con esposo migrante necesitan educación sobre la planificación familiar relacionada con sus circunstancias específicas y acceso a una gama más amplia de opciones de planificación familiar. La consejería de calidad debe respetar las experiencias de las mujeres con efectos secundarios e incluir una discusión a fondo de alternativas viables.