

Abstract

This study investigates perceptions of “who” (husband/wife/both) makes reproductive and contraceptive decisions. Findings reveal that men and women have different perspectives; the majority of the women perceived most decisions as being made jointly, while most men perceived them as being made either by themselves, their wives, jointly, or by no one. Disagreement in naming the decision-makers among couples indicates that spouses lack communication regarding reproduction and contraception matters. Predictions resulting from a quantitative analysis of the data indicate that among users and nonusers, women perceive that men are more likely to make the decision to have another child, but neither men nor women perceive that a woman might make that decision. Data concerning the use of contraceptive methods show that more couples practice male-controlled methods than female-controlled methods.

Recommendations are made to include husbands independently of their wives in educational workshops about contraception in order to open the channels of communication among couples; for those couples who can agree on a contraceptive method, it is suggested that husbands could be involved in supporting their wives’ use and continuation of a method.

About the Author

Gisele Maynard-Tucker, PhD, a medical anthropologist, is currently Senior Research Associate at International Health and Development Associates in Malibu, California. She has conducted research on family planning, maternal and child health, and reproductive health in Peru, Haiti, Indonesia, Morocco, and Nepal. Her work has been published in *Studies in Family Planning*, in *Working Papers on Women in International Development*, and in *Health Policy and Planning*.

Men’s and Women’s Reproductive and Contraceptive Decisions: A Case Study from Highland Peru

by

**Gisele
Maynard-Tucker**

International
Health and
Development
Associates

Women and International Development
Michigan State University
202 International Center, East Lansing, MI 48824-1035
Phone: 517/353-5040; Fax: 517/432-4845
E-mail: wid@msu.edu; Web: <http://www.isp.msu.edu/WID/>

Working Paper
#248
October 1994

MEN'S AND WOMEN'S REPRODUCTIVE AND CONTRACEPTIVE DECISIONS: A CASE STUDY FROM HIGHLAND PERU

Introduction

In most patriarchal families, power and authority are ascribed to husbands, and wives usually expect that their husbands will make most of the decisions. In reality, however, there are variations between couples and within cultural patterns, depending on the spouses' level of education, individual preferences, social status, economic input, and personal values (Beckman 1978, 1983, 1984; Blood and Wolfe 1960; Bradsley 1987; Harris 1978; Hollerback 1980; Mott and Mott 1985; Shain and Jennings 1980). The difficulty arises when one wishes to measure a spouse's individual power, influence, bargaining and exchanges within the process of making decisions.

Most contraceptive methods are designed for women's physiology; therefore, it is often assumed that women make their own decisions about using modern contraceptives, but this is not always so. Recent cross-cultural studies examining men's attitudes concerning their wives' use of contraception reveal that men have an important role in decision-making and that many women need their partners' approval to use a method. Shedlin and Hollerbach (1981) report that in Mexico women cannot make any decision about the use of contraception without consulting their husbands. Browner (1978), working in Ecuador, also found that men's attitudes affect their wives' decisions regarding the use of contraceptives. Similar findings were reported by Harris (1979); Hollerbach (1980); and Scrimshaw (1978). In Zimbabwe, it was found that men have a major role in making decisions about using family planning methods and in determining how many children a couple should have (Adamchak and Mbizvo 1991). A study conducted in urban Sudan reported that husbands make the decision about the use of modern contraception, and among users, husbands take the responsibility for providing their wives with contraceptives (Khalifa 1988). Another study from rural Ghana revealed that the husbands' positive involvement in family planning contributed to a decline in fertility (Lamptey et al. 1978). During a survey conducted in Indonesia, wives reported that they needed their husbands' approval for the practice of a contraceptive method (Joesoef, Baughman and Utomo 1988).

This new focus on men's roles and involvement regarding contraception suggests a new approach to family planning programs. In some countries, programs originally established to reach only women are increasingly promoting workshops for men (Gallen, Lisking and Kak 1986) but more research is needed to investigate men's attitudes, practices, and involvement (Davies, Mitra and Schellstede 1987; Adamchak and Mbizvo 1991; Sachs 1994). Within the context of a couple, the fragile interplay of husband's and wife's decision-making power is a complex issue because decision-makers are not always clearly defined and because circumstances and personalities intervene. Thus, any research aimed at uncovering couples' decision-making strategies about reproduction and contraception would contribute

to program planners' better understanding of spouses' strategies concerning the process of decision-making.

This study is based on research conducted in 1986, in a highland community located near the city of Cuzco. The study examines Quechua men's and women's decision-making processes concerning six reproductive decisions, and reports their disagreement in naming the decision-makers. Quantitative data are used to predict which of the genders is perceived to have more influence in the decision-making process. Men's involvement in the practice of contraception is examined in relation to their choice of contraceptive methods. The final discussion analyzes cultural factors which influence men's and women's inequities in decision-making. Suggestions are given for the establishment of workshops which would enhance communication among spouses about reproductive and contraceptive matters and would involve the most progressive husbands in supporting their wives' use and continuation of a method.

Demographics

In Peru, women living in rural regions average 6.2 live births, and child mortality is estimated at 101 per 1,000. In these regions, the illiteracy rate is higher for women (70.4 percent), than it is for men (33.6 percent) (ENDES 1991-92). During the last few years "la alza" (inflation) has brought immense monetary stress among the indigenous population. Lured by the better opportunities for work offered in urban centers, numerous "serranos" (highlanders) have migrated to the "barriadas" (slum areas) of Lima. For the men and women living in highland rural communities, the search for cash-wages in order to buy foodstuffs, household necessities and clothing is a daily burden. Couples confronted by the never-ending struggle for survival are increasingly aware of the implications of a large family and are therefore more willing to limit their own family size.

The Location and the People

Markita (a pseudonym) is a village of approximately 3,500 inhabitants, located about 35 minutes by bus from Cuzco. Houses are constructed of adobe, the majority of which have no piped water, latrines or electricity. Inhabitants make a living from artisan work, migratory wage-labor, and agriculture. They produce (in small quantities) potatoes, tarwi (seeds to make oil), onions, barley and wheat. Arable land is scarce in the community, plots are small and villagers have no money to invest in fertilizers. Not everyone owns a plot of land, however: about one-third of the population is landless because it is composed of migrants from distant communities who settle in Markita while waiting to secure enough money to migrate to Cuzco or Lima.

In Markita, subsistence farming is usually supplemented by unskilled wage-labor performed by men in neighboring rural communities or in Cuzco. Some husbands migrate for a few days during the week while others migrate for several months at a time, leaving their wives and children in the village. It is not unusual for migrating husbands to establish

another family during their period of migration. About 25 percent of the husbands interviewed reported a second family elsewhere. The majority of the wives interviewed also participate in the family's quest for cash--they sell produce at the market, the train station, and they set up roadside stands to sell home-made cooked foods.

Inhabitants are bilingual in Quechua and Spanish, but women prefer to speak Quechua. Because both genders often travel to Cuzco, they exhibit varying degrees of Western acculturation.¹ Most children attend school daily from the age of 6 to 18 years; parents hope that an education will permit their children to acquire professional skills to promote a better life for the whole family.

Methods

Data for this study were collected from June to October 1986 while living in Markita. Three previous periods of research (1980, 1981, and 1984)² in the community enabled me to establish trust and friendship among the informants, so that they would respond to my intimate questions about their sexual lives. This is a difficult subject to raise due to the shame associated with sexual matters for women, and because spouses usually do not communicate their feelings about reproductive matters. During the inquiry, a section of the village was selected at random, and in that section each house was surveyed. A total of 276 respondents were interviewed: 110 couples, and individual persons (45 women and 11 men), who were in unions but with absent spouses at the time of the interviews. In total, 155 women and 121 men were interviewed. The author interviewed wives, between the ages of 19 and 49 years, in their homes or at their places of work (while selling on the roads or at the market). Husbands were interviewed on different days in the evening or during the weekends by a male student from the University of San Abad de Cuzco, trained by the investigator. Based on previous research in the community, two questionnaires were composed for the study and were translated into both Spanish and Quecha. The investigator speaks both languages.

One instrument inquired about demographic data, attitudes, knowledge, practice and opinions of modern contraceptives. The other inquired about who (husband/wife/both) makes decisions concerning economic, domestic and reproductive matters. Each category was composed of six questions. The aim of questions was to elicit informants' perception of the decision-maker for each decision, rather than who accomplishes the decision, because the latter is subject to situational circumstances. Interviews lasted 45 minutes and were supplemented with participant observations. For the purpose of this study, only the answers in the reproductive category are analyzed.

Fieldwork Strategy

During my previous research in the community, I learned that women would speak more freely if I could be alone with them during the interviews. I also knew that if children and men were nearby and could listen to my questions, informants might be embarrassed

to answer. Consequently, I started interviews by jokingly requesting that we be alone because children and men should not hear "women's talk." This was not difficult to accomplish, because the culture emphasizes a gender division of labor and social concerns. This strategy allowed me to communicate freely with informants on the basis of our gender and permitted them to respond to my questions without embarrassment. Also, because I had been involved in the community previously, I had become a comadre (godmother) in several families--a fictive kin relationship which promoted acceptance and trust from informants. Male informants were also isolated from their wives and children during interviews and spoke freely with the male investigator based on their gender affinities.

Findings

Men's and Women's Attitudes Toward Contraception

When asked about their opinions regarding modern contraception, fewer men (67/121 or 55 percent) than women (48/155 or 70 percent) approved of modern contraception. For both genders, the major objection to the use of contraceptives was the fear of side effects of the methods, followed by monetary cost; loss of time (e.g., waiting to see the doctor at the health post, having to go to Cuzco to visit a private doctor) and hearing about failures of the methods as experienced by friends. When we asked respondents how they influenced their wives to control their fertility, 55 percent of the men replied that they told their wives "to go cure themselves" ("ve a curarte") by a doctor at the health post, at the hospitals, or at the office of private doctors.

Data show that 55 percent of the men had a positive attitude toward contraception, with 35 percent opposing it, and about 10 percent indicating ambivalence. When asked whether, if satisfied with a method, they would tell their friends about it, 92 percent of the men interviewed replied positively, but only 40 percent of the women would do so--the women felt that if they talked about it, their friends might gossip about their sexual lives.

Concerning what was most important in their lives, 60 percent of the men answered their work, and 80 percent of the women responded their children. The majority of the informants thought that three children (2 boys and 1 girl) per family would be ideal, although women averaged 4.0 children by age 28. Surprisingly, the questionnaire revealed that the majority of wives believed that their husbands wanted one or two children more than the number answered by their husbands.

Among informants, a small group of women complained that their husbands kept them pregnant all the time because they were jealous, while some husbands said that modern contraceptives would promote promiscuity among their wives and would destroy their union. Almost all the women (90 percent) reported that they would not dare practice a method without the consent of their husband, because if they did so, they would be accused of being unfaithful. Interestingly, men were not inclined to blame themselves for their wives' frequent pregnancies, but instead expressed the opinion that women's fertility

was uncontrollable and assessed that it was her responsibility to "cure" herself by seeing a doctor).

Husbands' and Wives' Perceptions of Decision-Makers

The data in Table I report the frequency scores and percentages of six questions asked individually of men (N=121) and women (N=155) in unions, as to which spouse makes the following reproductive decisions: who decides to have another child, to use a method, to get information about contraception, to limit family size, to abort, and to visit a doctor or a health center. Respondents' answers to these questions fell within four categories as follows: (1) themselves, (2) their partners, (3) jointly, (4) no one.

Fertility frequency scores and percentages in Table I indicate that men and women have different perceptions of who is the decision-maker. Answers to the first question "who decides to have another child" revealed that more women (57%) than men (38%) felt that the decision was made jointly, however, 36 percent of the men said that no one decides. The decision to use a method was perceived by most men (54%) and women (64%) as a joint decision, although more women (29%) than men (24%) perceived it as their decision. Respondents' answers to the question asking "who gets information about contraception" indicated that more women (58%) than men (37%) perceived it as a joint decision; however, about 38 percent of the women also felt that it was their decision compared to 26 percent of the men. Answers to the question "who decides to limit family size" indicate that more women (76%) than men (64%) perceive that this decision is made jointly. The decision to abort shows some conflicting answers; for example more women (62%) than men (34%) said that it was a joint decision, although about 26 percent of the men and 16 percent of the women reported that no one decides, in addition, only one percent of the women said that it is the husband's decision, while men (19%) said that it was the wife's decision. The decision to visit a doctor was perceived by women (55%) and men (44%) as the wife's decision, although a third (37%) said that it was a joint decision.

To summarize, disagreement in naming the decision-makers suggests that about two-thirds of the men and one-third of the women do not communicate with their partners concerning reproductive issues. While women perceive that most decisions are made jointly, men have a more divided view of the decision-makers; they named themselves, their wives, or both. Overall, more men than women said that no one decides for most of the decisions. Furthermore, except for the decision to have another child, to which about a third of the women said that it was the husband's decision, more women named themselves as the decision-makers than did men, and more men than women named their partner as the decision-maker. Disagreement in naming the decision-makers indicates that husbands and wives each have a personal opinion regarding who should make the decision but they do not discuss it openly with their partner.

New Concepts and Traditional Behaviors

Data also reveal that there is more disagreement among couples if the decision is linked to issues and behavior which are not part of the life routine and responsibilities. For example, some informants said that the decision to have another child had never been a decision until the emergence of modern contraception which permits women to control their fertility. An older informant explained, "in the old days, we had all the children that God sent us, we had no choice." Likewise, the decisions "to get information," "to use a method" and "to limit family size" represent new concepts for the Quechuas as they have no past experience using modern contraceptives. For example, more women than men perceived that these decisions were made jointly, and more women than men said that it was a woman's decision. This is probably due to the fact that the use of contraception is assumed to be a woman's responsibility, as most methods are designed for female physiology.

From the point of view of the women, the decision to abort appears to be made jointly or by the woman. It is a decision that women made and continue to make with or without the consent of their husbands. Before the emergence of modern contraception, abortion was a popular means to control unwanted pregnancies. Presently, abortion is practiced frequently without the accord of husbands (Maynard-Tucker 1988), although the majority of the women explained that they prefer the approval of the husband and his financial help to pay for the operation. Finally, most men and women attributed the decision to visit a doctor to women. It is a decision which is part of a woman's routine responsibilities. Women visit traditional healers and physicians when children are ill and for their own ailments, but men rarely visit practitioners unless they are very sick. There is also a long tradition in the community of the use of herbal teas to cure most illnesses and to prevent unwanted pregnancy or provoke abortion, these teas being prescribed by traditional healers. Table II shows that among the women interviewed, 12 percent (9/110) of the women reported using herbal teas to prevent unwanted pregnancies.

To summarize, data suggest that among spouses there is more disagreement in naming the decision-makers when decisions are linked to new concepts and behaviors. When decisions are linked to men's and women's routine responsibilities, however, answers show more agreement.³

Governmental Policies Regarding Modern Contraception

In Peru, a woman seeking information about contraceptive methods in health facilities or at private physicians must be accompanied by her husband. Likewise, if a woman wants a tubal ligation she must be accompanied by her husband during the medical visit and during the surgery.⁴ In some situations when the husband cannot be present and depending on the attitudes of physicians and the requirements of certain facilities, the woman might be able to bring a written note signed by the husband stating his approval. These policies create great constraints for women whose husbands are usually not free during the day to accompany them to health posts, physicians' offices, or hospitals (most

family planning services are offered from 8:00 a.m. to 2:00 p.m.). In general, husbands leave home for work in the early morning around 6:00 a.m. and return in the evening around 7:00 p.m. In addition, seasonal employment causes many husbands to be absent for weeks or months at a time.

These restrictions reinforce the authority of the husband over his wife, although on two occasions I witnessed women fooling doctors by presenting letters written in the name of the husbands in order to get a contraceptive method. But these women are exceptions; in general, most women comply with the policy which requires the presence of the husband.

Quechua Men's Involvement in Contraceptive Practices

Men's predominance in making decisions about contraception is revealed by the couples' reported contraceptive practices. Table II shows couples (N=110) reported use of contraceptive methods and husbands' extent of disagreement with their wives for, as noted, the husbands' answers were in discord with those of the wives (28/110=25%). Compared to the wives' answers, about half of these husbands (14/119=13%) under-reported their wives' methods and about half (14/110-13%) over-reported the use of condoms, rhythm and withdrawal. Some husbands reported practicing the rhythm method in addition to their wives' modern methods, as a precaution, in case the wives' methods failed. Some wives were using contraceptives without their husbands' knowledge. In addition, data show that more couples practice male-controlled methods (44 percent) than female-controlled methods (34 percent). The rhythm and withdrawal methods and the use of condoms are methods usually chosen and regulated by husbands. Rhythm is the preferred method among men. Among the couples who were using the rhythm methods, some wives could not explain the mechanisms of the method, and told us that their husbands were in charge of the method because they knew more about the body and the method. Only four couples could explain the practice correctly. The rhythm method is usually practiced incorrectly because there are cultural taboos concerning menstruation (Maynard-Tucker 1989). The period of sexual abstinence is observed during menstruation not only because many believe that ovulation occurs at that time, but also because menstrual blood is thought to be dangerous to men's sexual organs (Snowden and Christian 1983).⁵

The withdrawal method reported by some husbands was denied by their wives who said that they did not know the method. As for the use of the condom, only four informants reported the use of condoms when with their wives. In general, men do not perceive condoms as a barrier to conception, but as a protection from venereal diseases. Husbands reported that the use of a condom would be insulting to their wives because they are "clean women." Most wives had not seen a condom. In addition, condoms are not easily disposed of because there is a lack of waste facilities. Couples lack privacy, sleeping in the same room with their children and with infants by their side.

Apart from controlling natural contraceptive methods, women need the approval of their husbands in order to seek information, to pay doctors' bills, and to practice birth

control methods openly. The majority of wives reported that they would not use contraceptives methods without their husband's knowledge because they feared their husband's physical punishment. Nonetheless, a small group of women confided that they made active decisions to use contraception on their own.

Quechua Women's Active Decisions to Use Modern Contraception

Among female informants, a small group of ten women reported that they were using a modern method surreptitiously. Most of them were involved in unstable unions. Five respondents said that their migrating husbands had a concurrent wife and family elsewhere, and explained that they did not want any additional children because their husbands might abandon them for the second wife. Among the remaining five women, three were married to violent, jealous husbands, and two were afraid to give birth again because they had had dreadful experiences with their last home deliveries.

The profiles of these ten women reveal that eight of them were successful vendors and were supporting their families partially or fully since their husbands were often unemployed. Overall, these eight women were able to make active decisions about the control of their pregnancies because they were more independent. They were working but were able to take time to visit a doctor and to pay for the visit and for contraceptives without asking their husband's permission or money. In addition, the husband's authority was weakened due to his frequent absences for work or for visits with the other wife, or because he was unemployed. In the community, a man's status is enhanced by his ability to support a wife and children with his wages. Husbands who are not working or who do not support their children are looked down upon by others and are subject to gossip and jokes, a situation which tends to decrease a man's authority over his wife.

Discussion

Modern reproductive and contraceptive decision-making is a new concern for Quechua couples. Despite their reports that indigenous methods of contraception (from plant medicines) have been practiced, during the interviews some women said "before, we could not prevent pregnancy, therefore no one was making decisions about having children or not." Overall the majority of informants reported making joint decisions; however, two-thirds of the men and one-third of the women were in disagreement over the naming of the decision-makers. Thus, it is important to distinguish between informants' perceptions of the decision-makers and the life circumstances or determinants which might change the outcome of the perceptions, such as informants' personality, level of education, absence of the husband, and women's economic participation. For example, more women than men reported that decisions are made jointly; but some wives also said that if the decision is disputed, husbands will have the last word. This implies that "joint decision" can be based on spouse' agreement or can be discussed and be subjected to husbands' approval. For the latter, the outcome will be influenced by the personality of the husband, his absence due to migratorial wage-labor, and the level of education of both partners. Couples who had had

at least 10 years or more of schooling showed less disagreement in their answers than couples represented by an illiterate wife and a husband who completed 5 or 6 years of schooling. The latter disagreed more often probably due to a lack of communication between spouses caused by the wife's cultural traditionalism and the husband's more westernized views.⁶

Couples' disagreement about the naming of the decision-makers also suggests that when new values and new behavior are acquired, tested, and slowly incorporated into the cultural pattern of decision-making, spouses' perceptions of the decision-makers cannot be determined until that new value or behavior is discussed by the spouses, and one of the spouses takes responsibility for it. As noted previously, some decisions are made unilaterally, and others are not discussed. One of them is the lack of communication regarding contraceptive use. For example, 25 percent of the husbands were in disagreement with their wives' answers to the use of a method. They also reported practicing the rhythm and withdrawal methods without consulting their wives, and sometimes in addition to their wives methods.

Men's and women's sexual separateness is reinforced by cultural norms. Usually, women do not communicate their most intimate feelings to their husbands because women must deny their sexuality for their reproductive role as mother in order to be praised as a "good woman." For men, a woman who wants too much sex or who talks about sex, is a "loose woman" who has had many sexual encounters. Wives must be pure, ignorant of sexuality, and faithful. These cultural values allow spouses to live intimately side by side as relative strangers. In the community, however, men's double standard is accepted and men who have more than one family and who maintain both families are praised as "good providers."

The lack of communication among couples about sexuality leads to uncertainty about the partner's feelings, and promotes a lack of trust, which usually develops into irrational accusations of unfaithfulness by both genders, and provokes physical violence. This causes many women to not make any decision on their own about using modern contraception, because they would be accused of unfaithfulness and could be battered by their husbands. Moreover, some women are tied to dreadful marital relationships for the economic survival of the children. Abandonment is feared because economic support, status and protection would be lost. The community does not approve of single motherhood; women need the protection and the status of their partner in order to be respected.

On the other hand, women's perceptions of men's roles reflect their socialization and cultural norms. Girls are not sent to school as often as boys because they are needed to help with household tasks, and consequently, their education is inferior to boys. Also, because there are cultural taboos concerning menstrual blood (which is feared by men), women are made to feel unclean, polluting and somewhat inferior to men. Statistical analysis (see Table II) suggests that among users and nonusers of contraception, women attribute authority to men for making the decision to have another child, but women do not

perceive themselves making such a decision. Furthermore, government policies requiring husbands' authorization for wives' use of modern contraception and sterilization perpetuate gender inequities and prevent women from taking control of their own bodies (Cook 1993). As noted, only those women who have the opportunity to be economically independent make active decisions about controlling their pregnancies and sometimes override their husband's authority.⁷

Conclusions

In conclusion, data suggest that men and women in unions have different perspectives of the decision-makers in the reproductive domain; the majority of the women perceive those decisions to be made jointly, while most men stated that such decisions are made either by the husband, the wife, jointly, or by no one. Moreover, findings suggest that decisions which represent new values and new behavior do not have a defined decision-maker, because these decisions are rarely discussed between spouses. Spouses' lack of communication and unilateral decision-making is illustrated not only by their disagreement in naming the decision-makers, but also in their discord in reporting the use of contraceptive methods. As noted previously, health care policies such as requiring men to accompany women who seek contraceptive information, emphasize men's authority and gender inequities concerning contraceptive decisions. Nonetheless, a few women, those who were economically self-sufficient, were able to make active decisions regarding control of their pregnancies. Women's economic independence might lead to greater desire for the control of their reproductive functions and should be the concern of the future family planning programs.

Couples' greater use of male-controlled methods compared to female-controlled methods suggest that many husbands make contraceptive decisions and are willing to control their family size. Consequently, men's involvement in contraception should not be pushed aside after getting their signature. Findings indicate that there is a need for workshops for both husbands and wives concerning communication over reproductive and contraceptive matters, and for those couples who can agree on a method, husbands should be enticed to support their wives' use and continuation of a method. Additional research about spouses' reproductive and contraceptive decision-making will provide much needed data on spouses' communication, will help to establish target groups, and will generate information for improving the quality of the family planning services.

Notes

1. Modernization is characterized by the use of Spanish to communicate, and by the clothing worn. Quechua women have not completely shed their traditional costume: they still wear the pollera, the traditional skirt made of bayeta (kicak weaving), which is worn with a modern sweater, and on their head the hat which is representative of the region. Men and children wear western clothing.
2. Previous research in the community examined: "The impact of male migration of women's roles" (1980); "The impact of modernization on the socialization of the children" (1981); and "Barriers to modern contraceptive use in rural Peru." (1984) (Studies in Family Planning 17(6):307-316).
3. Findings about who makes household decisions reveal that men usually make the most important decisions (such as where to live, what furniture to buy, or what cattle to buy), while women's decision-making is mostly limited to their traditional role responsibilities (such as buying guinea pigs or chicken, going to mass, visiting friends).
4. I was told that if a man wants a vasectomy, the wife must give her authorization for the surgery. However, vasectomy is not popular in the Andes because men believe that the surgery leads to impotency. Moreover, it is not promoted because there is a lack of medical staff trained to perform the surgery.
5. Men believe that contact with menstrual blood leads to blindness and impotency, and that it could infect the urethra because menstrual blood is "dirty" ("sucia").
6. Education is emphasized more for boys than for girls because parents hope that boys will become professionals and will support them during old age. Girls are not expected to become professionals, but are expected to become housewives. Many couples show different levels of schooling; for example one of the elementary school teachers was married to an illiterate woman. He wore western clothing and spoke Spanish fluently, while she was very traditional, wore the traditional skirt and hat, and spoke very little Spanish. He knew the mechanisms of the rhythm method but she did not.
7. Programs offering workshops about learning to read and write, sewing, knitting, cooking, and making regional artifacts would help women find jobs or start a cottage industry, and subsequently become economically independent.

Table I

Frequency Scores and Percentages of
Reported Fertility Decision
Men N=121 and Women N=155 in Unions

Decisions	Men's Answers N=121				Women's Answers N=155			
	Wife N	Husband N	Both N	None N	Wife N	Husband N	Both N	None N
1. To have another child	8 *(6)	22 (18)	47 (38)	44 (36)	4 (2)	49 (32)	88 (57)	14 (9)
2. To use a method	18 *(15)	29 (24)	66 (54)	8 (6)	45 (29)	10 (6)	99 (64)	1 (.6)
3. To get information	33 *(27)	32 (26)	45 (37)	11 (9)	59 (38)	5 (3)	90 (58)	1 (.6)
4. To limit the family	11 *(9)	28 (23)	78 (64)	4 (3)	26 (17)	8 (5)	118 (76)	3 (1)
5. To abort	23 *(19)	25 (21)	41 (34)	32 (26)	30 (19)	3 (1)	97 (62)	25 (16)
6. To visit a doctor or a medical center	53 *(44)	24 (20)	31 (26)	13 (11)	86 (55)	11 (7)	57 (37)	1 (.6)

* = Percentages

Table II

**Husbands' Controlled Contraceptive Methods
and Disagreement Over Wives' Answers
to the Use of Contraception
N=110 Couples**

Male Controlled Methods

Methods	N	Extent of Husband' Disagreement*
Rhythm	37	+9
Withdrawal	4	+2
Condom	2	+2
Tubal Ligation	5	0
Total male controlled methods	48	13

Female Controlled Methods

Methods	N	
IUD	13	-1
Pill	11	-4
Depo-Provera	5	+1
Herbal teas	9	-6
Total female controlled methods	38	12

<u>Nonusers</u>	24	-3
Total	110	28

Data show that among the 110 couples interviewed, more couples (44%) use male controlled contraceptive methods than female controlled methods (34%)

*When both husbands and wives were asked separately what contraceptive methods they were using, husbands' answers were in disagreement with their wives' answers. About 25% of the husbands over-reported (the + sign) or under-reported (the - sign) their wives' use of a contraceptive method.

References

- Adamchak, D. and M. Mbizvo
1991 Family Planning Information Sources and Media Exposure among Zimbabwean Men. Studies in Family Planning 22:326-332.
- Beckman, L.J.
1978 Couples Decision-Making: Processes Regarding Fertility. In: Social Demography, edited by K.E. Taeuber L. Bumpass and J.A. Sweet. Pp. 57-81. New York: Academic Press.
1983 Communication, Power, and the Influence of Social Networks in Couples' Decisions on Fertility. In: Determinants of Fertility in Developing Countries, Vol. 2, edited by R.A. Bulafao and R.D. Lee. Pp. 415-444. New York: Academic Press.
1984 Husbands' and Wives' Relative Influence on Fertility Decisions and Outcomes. Population and Environment 7(3):182-197.
- Blood R. and Wolfe D.
1960 Husbands and Wives: The Dynamics of Married Living. New York: Free Press.
- Bradsley, P.
1987 The Role of Conjugal Power in the Fertility Decision Making Process. Ph.D. Dissertation, Department of Public Health, University of California, Los Angeles.
- Browner, C.
1978 Abortion Decision-Making: Some Findings from Colombia. Studies in Family Planning 10:96-106.
- Cook, R.
1993 Human Rights in Relation to Women's Health. Geneva: World Health Organization.
- Davies, J. S. Mitra and W. Schellstede
1987 Oral Contraceptive in Bangladesh: Social Marketing and the Importance of Husbands. Studies in Family Planning 18:157-169.
- Encuesta Demografica y de Salud Familiar de la Republica del Peru (ENDES)
1991 The Peru Demographic and Health Survey. Intsituto Nacional de Estadistica e Informatica DHS Program of Macro International Inc.

- Gallen, M. L. Liskin, and N. Kak
 1986 Men--New Focus on Family Planning Programs. Population Reports, No. 33.
 Baltimore: Johns Hopkins University Press.
- Harris, O.
 1978 Complementarity and Conflict: An Andean View of Women and Men. In: Sex and Age as Principles of Social Differentiation, edited by J.S. La Fontaine. Pp. 21-40.
 City: Publisher.
- Hollerback, P.
 1980 Power in Families: Communication and Fertility Decision-Making. Population and Environment 3:146-173.
- Joesoef, M.R., A. Baughman, and B. Utomo
 1988 Husband's Approval of Contraceptive Use in Metropolitan Indonesia: Program Implications. Studies in Family Planning 19:162-169.
- Khalifa, M.
 1988 Attitudes of Urban Sudanese Men Toward Family Planning. Studies in Family Planning 19:236-244.
- Lamprey, P., D.D. Nicholas, S. Ofori-Amaah, and I.M. Lourie
 1978 An Evaluation of Male Contraceptive Acceptance in Rural Ghana. Studies in Family Planning 9:222-226.
- Maynard-Tucker, G.
 1988 Reproductive Decision-Making and the Use of Modern Contraceptives in Rural Peru. Doctoral Dissertation, University of California at Los Angeles, Department of Anthropology.
 1989 "Women Status as a Factor in Male and Female Decision Making About the Use of Contraception: A Case Study from Rural Peru. Working Papers on Women in International Development #191. East Lansing, MI: Women and International Development Program, Michigan State University.
- Mott, F.L., and S.H. Mott
 1985 Household Fertility Decisions in West Africa: A Comparison of Male and Female Survey Results. Studies in Family Planning 16(2):88-99.
- Sachs, A.
 1994 Men, Sex, and Parenthood. World Watch 7(2):12-19.

Scrimshaw, S.

1978 Stages in Women's Lives and Reproductive Decision-Making. Medical Anthropology 2(3):41-58.

Shain N.R., and V.H. Jennings

1980 The Influence of Sex Role on Fertility. In: Fertility Control: Biologic and Behavioral Aspects, edited by R.N. Shain and C.J. Pauerstein. Pp. 277-289. Hagerstown: Harper and Row.

Shedlin, M. and P. Hollerbach

1981 Modern and Traditional Fertility Regulation in a Mexican Community: The Process of Decision-Making. Studies in Family Planning 12:279-296.

Snowden, R. and B. Christian (editors)

1983 Patterns and Perceptions of Menstruation. World Health Organization. New York: St. Martin's Press.

WOMEN AND INTERNATIONAL DEVELOPMENT PROGRAM
MICHIGAN STATE UNIVERSITY
ISSN# 0888-5354

The WID Program at Michigan State University began its *Women in International Development Publication Series* in late 1981 in response to the need to disseminate the rapidly growing body of work that addressed the lives of women in Third World countries undergoing change. The series cross-cuts disciplines and brings together research, critical analyses and proposals for change. Its goals are: (1) to highlight women in development (WID) as an important area of research; (2) to contribute to the development of the field as a scholarly endeavor; and (3) to encourage new approaches to development policy and programming.

The *Working Papers on Women in International Development* series features journal-length articles based on original research or analytical summaries of relevant research, theoretical analyses, and evaluations of development programming and policy.

The *WID Forum* series features short reports that describe research projects and development programs, and reviews current policy issues.

EDITOR: Anne Ferguson
MANAGING EDITORIAL ASSISTANTS: Pam Galbraith
DISTRIBUTION & PRODUCTION MANAGER: Barry Crassweller

EDITORIAL BOARD: Margaret Aguwa, Family Medicine; Marilyn Aronoff, Sociology; James Bingen, Resource Development; Ada Finifter, Political Science; Linda Cooke Johnson, History; Assefa Mehretu, Geography; Anne Meyering, History; Ann Millard, Anthropology; Julia R. Miller, College of Human Ecology; Lynn Paine, Teacher Education; Paul Strassmann, Economics; David Wiley, African Studies Center; Jack Williams, Asian Studies Center; Kim A. Wilson, Institute of International Agriculture; Khalida Zaki, Department of Sociology.

NOTICE TO CONTRIBUTORS: To provide an opportunity for the work of those concerned with development issues affecting women to be critiqued and refined, all manuscripts submitted to the series are peer reviewed. The review process averages three months and accepted manuscripts are published within ten-to-twelve weeks. Authors receive ten free copies, retain copyrights to their works, and are encouraged to submit them to the journal of their choice.

Manuscripts submitted should be double-spaced, sent in duplicate, on disk or emailed (to wid@pilot.msu.edu) in WordPerfect compatible format and include the following: (1) title page bearing the name, address and institutional affiliation of the author; (2) one-paragraph abstract; (3) text; (4) notes; (5) references cited; and (6) tables and figures. The format of the article must follow the format as depicted in our "Style sheet". Submit manuscripts to Anne Ferguson, Editor, WID Publication Series, Women and International Development Program, 202 International Center, Michigan State University, East Lansing, MI 48824-1035, USA. Style sheets are available upon request.

TO ORDER PUBLICATIONS: Publications are available at a nominal cost and cost-equivalent exchange relationships are encouraged. To order publications or receive a listing of them, you may write to the WID Program, 202 International Center, Michigan State University, East Lansing, MI 48824-1035, USA or check out our Web site (<http://www.isp.msu.edu/wid/>) which also has all the ordering information and an order form. Orders can also be sent to us via email at (wid@pilot.msu.edu).