



LUNDS
UNIVERSITET

Lund University Master of Science in
International Development and Management
May, 2018

Family Planning (In)Activity

*A Case Study of Women and Men's Role and Responsibility on Family Planning
in Metro Manila, the Philippines*

Author: Katarina Lindgren Cortés
Supervisor: Moira Nelson

Abstract

Having access to family planning (FP) services is a cornerstone for economic and social development. Because of reproductive health disparities between income groups, progressive policies have been passed in the Philippines to reduce the gaps. One example is the Responsible Parenthood and Reproductive Health act that provides people living in poverty with FP services. Moreover, it attempts to promote responsible parenthood, which involves both mothers and fathers. By interviewing 16 women and men, residing in two poor urban communities in Metro Manila, this thesis set out to explore their respective role and responsibilities in matters concerning FP. The findings demonstrate a gendered division of roles and responsibilities where women bear the main responsibility in preventing pregnancies while men lack concern, which corresponds and adds to the literature on the field. Using concepts of power, gender norms and roles, and agency this thesis argues that constructed gender norms and roles inform women and men on how to be involved in FP. Despite the sample size, the findings direct attention to prevailing power structures that not only burden mothers but also impede fathers from getting informed and from becoming responsible fathers.

Keywords: Contraceptives, Family Planning, Sexual and Reproductive Health, Responsible Parenthood and Reproductive Health act, Philippines, Urban Poverty, Power, Agency, Gender norms and roles, Feminization of Contraception.

Word count: 14904

Acknowledgements

There are various persons to which I would like to express my gratitude.

First of all, to all of you participating in this thesis, for your generosity in taking your time and sharing your views with me and for inviting me to your homes. Thank you for the trust and for the patience you showed me. Salamat po.

To all of you involved in introducing me to the informants, more specifically Women's Global Network for Reproductive Rights, Woman Health and D2Ka. For the coordination and kind support, a special thanks to Luisa Lentejas at Woman Health and Leslie and Cecile at D2Ka.

To Margarita Dantes, Zimri Espaldon, and Jeffrey Ordoyo for assisting me in the field with your bilingual skills.

To my supervisor Moira Nelson, thank you for the guidance throughout the research process.

Finally, to my love and companion who has the ability to make me laugh in the most stressful moments.

Table of Contents

ABSTRACT	II
ACRONYMS	V
1. INTRODUCTION	1
1.1 PURPOSE AND RESEARCH QUESTION	2
1.2 DELIMITATIONS	2
1.3 OUTLINE OF THESIS.....	3
2. BACKGROUND	4
2.1 SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS.....	4
2.2 FAMILY PLANNING AND CONTRACEPTIVES.....	4
2.3 SEXUAL AND REPRODUCTIVE HEALTH IN THE PHILIPPINES	5
2.3.1 <i>Catholic Values</i>	5
2.3.2 <i>The Responsible Parenthood and Reproductive Health Act</i>	7
2.3.3 <i>Contraceptives under the act</i>	8
3. THE UNDERPINNINGS OF FAMILY PLANNING	10
3.1 POPULATION CONTROL.....	10
3.2 FEMINIZATION OF CONTRACEPTION.....	11
4. THEORETICAL FRAMEWORK	12
4.1 POWER	12
4.2 GENDER NORMS AND ROLES	13
4.3 AGENCY	14
5. METHODOLOGY	17
5.1 RESEARCH DESIGN.....	17
5.4 SAMPLING AND DATA COLLECTION.....	18
5.5 DATA ANALYSIS	23
5.6 ETHICS, POSITIONALITY, REFLEXIVITY AND POWER	24
5.7 TRUSTWORTHINESS.....	26
5.8 LIMITATIONS	27
6. FINDINGS AND ANALYSIS	29
6.1 A WOMAN’S BODY, A WOMAN’S CONCERN	29
6.2 WOMEN’S CONTROL AND FERTILITY WORK.....	31
6.3 THE POWER DYNAMIC OVER CONTRACEPTIVES	34
6.4 MALE CONFIDENCE AND VULNERABILITY	36
7. CONCLUSIONS	39
REFERENCES	41
APPENDICES	49
APPENDIX A.....	49
APPENDIX B	51
APPENDIX C	53

Acronyms

DOH	Department of Health
FP	Family Planning
HIC	High-Income Countries
ICPD	International Conference on Population and Development
IUD	Intrauterine Contraceptive Device
LGU	Local Government Unit
LMIC	Low- and Middle Income Countries
POA	Programme of Action
RH	Reproductive Health
RPRH	Responsible Parenthood and Reproductive Health
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights

1. Introduction

Access to family planning (FP) services is crucial for social and economic development (UNFPA, 2016; Pillai and Gupta, 2011; Wernet, 2016; Vistro, 2014). It is also considered a cornerstone for women's empowerment since having access to FP services put women in control over their fertility cycles and enables them to participate in society (Jacobstein et al. 2013; UNFPA, 2016; Cates and Maggwa, 2014). Despite FP services being crucial for both partners to avoid or delay pregnancies women usually take the largest responsibility over contraceptives (Bertotti, 2010; Fennel, 2011). Authors have found that matters concerning contraceptives are perceived as women's sphere, which has created a gendered division of labor where women usually bear the burden of seeking information about, obtaining and taking/using the contraceptive (Bertotti, 2010; Fennel, 2011).

In the Philippines, high disparities in meeting desired fertility goals prevail across income groups (Cabral, 2016). Studies have found that women living in poverty tend to have more children in relation to their desired fertility goals than women from wealthier households (Lai et al. 2017; Cabral, 2016). In targeting inequalities that disproportionately affect women from lower income groups, the government has passed progressive policies to decrease the gap. The Responsible Parenthood and Reproductive Health No.10354 (RPRH) act, which was passed in 2012, promotes health equity (RPRH, 2012). While the act mandates the state to provide FP services across the country, individuals living in poverty are given the services for free (RPRH, 2012). Adding to that, not only women and mothers are in focus of the act but it also involves men and fathers, as it enables both parents to access information and services to become responsible parents (RPRH, 2012). This is of particular importance since focusing exclusively on women could be problematic as it can reinforce FP issues as a matter for women only. Studies involving Filipino men have addressed their influence on fertility desires and their role as opposing choice of contraception (Abada and Tenkorang, 2012; David and Atun, 2014; Guttmacher institute and Likhaan, 2010), but lack in addressing their role and responsibility on matters related to FP. Therefore, it is important to incorporate the voices of men to gain insight in how they are involved in FP. However, as the responsibility of these matters usually lie with women, it is further important to involve both women and men to get a thorough understanding of their respective role and responsibility on matters

concerning FP. Incorporating the perceptions of both women and men can further help shed light on underlying structures that shapes their respective involvement.

1.1 Purpose and Research Question

This thesis aims to explore the role and responsibility of women and men living in poor urban communities on matters concerning family planning and contraception. It thereby focuses on the voices of women and men in describing their views on their respective role and responsibilities. Their perspectives play the central part in the analysis where concepts of power, gender norms and roles will be used to gain deeper understanding of their roles and responsibilities. This is of particular importance as it can help to inform the RPRH act on local power structures that in turn shape the role and responsibilities of parents.

Thus, this thesis is guided by the following research question:

- How do women and men in poor urban communities describe their role and responsibility on matters related to family planning and how can it be understood using concepts of power, gender norms and roles, and agency?

To clarify the purpose and research question, “role” refers to the purpose a person has in matters concerning FP and contraceptives. “Responsibilities” refers both to the perceived responsibility and the duties around the contraceptive, i.e. information seeking, obtaining, and taking/using it.

1.2 Delimitations

Recognizing the range of FP this thesis focuses on contraceptives. Adding to that, it focuses only on heterosexual individuals and couples. Furthermore, it is based on primary data collected in two urban poor communities in Metro Manila, more specifically Bagumbong and Batasan Hills. Despite data collected on which type of contraceptives was used, this thesis has not conducted any comparison between the different contraceptive users and its implication to their role and responsibilities. Finally, this thesis has not interviewed couples, but rather women and men in relationships or singles focusing on how they describe their role and responsibilities on matters to contraceptives. Hence, it has not looked into the negotiation between couples or how couples themselves describe their role and responsibility.

1.3 Outline of Thesis

This thesis starts with clarifying concepts related to FP and continues with a contextual background to the Philippines. Thereafter, the underpinnings of FP are presented, which is followed by the theoretical framework. After a methodological discussion, the findings and analysis of this thesis are presented. Finally, the thesis ends with final concluding remarks.

2. Background

To be able to understand the role and responsibility of women and men on matters concerning FP and contraceptives, it is important to understand what such services entails. Therefore, the definitions of sexual and reproductive health and rights, FP and contraceptives will be presented below. It will also provide a background to the Philippine context shedding light on social structures and legislation that creates the foundation in which roles and responsibilities of women and men play out locally.

2.1 Sexual and Reproductive Health and Rights

Sexual and reproductive health and rights (SRHR) refers to a person's right to a responsible, safe and satisfying sex life, which involves having the freedom to choose if, when and the spacing of desired number of children (UNFPA, 2017, 18; Starbird et al. 2016). Regardless of age, income, place of residence, marital status and sexual orientation, it gives individuals the right to SRH services and information to be able to live and enjoy their sexuality (UNFPA, 2017, 18). This entails having access to appropriate services to meet their desired fertility goals and needs and to be able to use such services without fear of discrimination (Pillai and Gupta, 2011; Wernet, 2016; Germain et al. 2015).

2.2 Family Planning and Contraceptives

For individuals and couples, FP services refer to the information, means and methods, i.e. contraceptives, to prevent or space the number of children (UNFPA, 2017b; PSA and ICF, 2018). To clarify, contraceptives is the means and methods for FP. Therefore, FP and contraceptives will be used interchangeably throughout this thesis. Contraceptive methods are usually grouped into two different kinds: modern and traditional methods (PSA and ICF, 2018; Lopez del Burgo and de Irala, 2016; UNFPA, 2017b). This thesis uses parts of Hubacher and Trussel's (2015) definition of modern contraceptives. Thus, modern methods refers to contraceptives that entails that a person uses a hormonal or non-hormonal product or conducts a medical procedure to hinder or stop reproduction from sexual intercourse (Hubacher and Trussel, 2015). Traditional contraceptive methods refer to methods that does not entail that a person uses any products or medical procedures to stop reproduction (ibid.).

Using the terms "modern" and "traditional" has been widely debated (Cates and Maggwa, 2014; Oas, 2016). Because of its definition, "modern" is usually associated with effectiveness,

which is not always the case and could therefore be misleading (Lopez del Burgo and de Irala, 2016). First of all, this definition lumps a long list of different contraceptive methods together, which all have different levels of effectiveness (Cates and Mattwa, 2014). For instance, longer-acting reversible contraceptives such as implants and IUDs are more effective than pills and injectable because the latter require regular actions and consistent use (Cates and Maggwa, 2014). Despite that various tools and techniques have been developed to improve the use of traditional methods, e.g. apps helping individuals to monitor their fertility cycles, these methods entail abstinence from sexual intercourse and are therefore classified as traditional (Hubacher and Trussel, 2015). Authors have emphasized the importance of a rights-based approach when providing individuals with contraceptive options as it can help individuals finding a method that aligns with her/his needs, which is crucial for an informed choice (Cates and Maggwa, 2014).

2.3 Sexual and Reproductive Health in the Philippines

In the Philippines, the prevalence of modern contraceptives has increased from 39 percent in 2013 to 45 percent in 2016 (Guttmacher Institute and Likhaan, 2010; DOH and POPCOM, 2017). This means that almost 5.7 million women are current users of modern contraceptives (Guttmacher Institute and Likhaan, 2010; DOH and POPCOM, 2017). The most common methods are contraceptives developed for women, such as Pills, sterilization, and IUD (DOH and POPCOM, 2017). Even though 89 percent of the population approves of modern contraceptives, the different aspects of SRH have been widely debated (Kennedy et al. 2011; David et al. 2012; Montiel et al. 2016).

2.3.1 Catholic Values

The majority of the population is Roman Catholic and the values of the Catholic Church prevail across society, politics, and legislation, which reflect the power of the Church in the Philippines (Collantes, 2018; Raffin and Cornelio, 2009; Parmanand, 2014). Life itself and the idea of the Filipino family are both sacred and supported by the Catholic Church (Collantes, 2018). While such values have developed the idea of children and what constitute a family, it has also prescribed roles for women and men (Collantes, 2018; Tanyag, 2017). In accordance to Catholic values women are portrayed as nurturing and self-sacrificing mothers, which has resulted in Filipino women being caring and compliant to their husbands' wishes in having more children than planned for (Tanyag, 2017; David and Atun, 2014). Since children are commonly seen as 'the gift of God', refusing the husband another child could be perceived as cruel and selfish by the husband and in the community (Greer, 2009; David and

Atun, 2014). This is emphasized by authors as putting additional pressure on women to comply with the role of the ‘nurturing mother’ (Greer, 2009; David and Atun, 2014). There are also prevailing masculinities that affect men in the Philippines. Having many children is commonly perceived as being fertile and strong, which authors have found affect the fertility goals of men who have a desire to have more children than their wives (Vistro, 2014; David and Atun, 2014). Such masculine norms are also reflected in the ‘macho-culture’ or manhood that prevails in the Philippines. Authors have found that masculine norms puts expectations on men in having many children, being good providers, in being negative towards male contraceptives and in ignoring household chores, which results in reproductive work being a woman’s issue (Eviota, 1992; Collantes, 2018; Pingol, 2001). As a result of such gender norms, Collantes (2018) argues that Filipino men are strengthened and Filipino women are undermined and undervalued in society.

In promoting Catholic values, the Roman Catholic Church has strongly opposed RH policies; particularly sexual education and state financed modern contraceptives (David et al. 2012, 299; Ruiz Austria, 2004). The stand of the Catholic Church derives from the idea that the use of modern contraceptives is a sin as they view modern contraceptives being abortifacient (Lim Tan, 2004; Bautista, 2010; Smith, 2014). As abortions are strictly criminalized in the country and the unborn have intrinsic rights in the constitution, it has resulted in campaigns run by the Catholic anti-abortion movement intersecting abortion with modern FP, arguing that such services are anti-family (Lim Tan, 2004; Collantes, 2018). As a result, the progress of SRH has to a large extent been influenced by the stand of the presidency, either being more liberal and promoting modern FP services or more conservative by promoting and supporting traditional FP that aligns with the values of the Catholic Church (David et al. 2012, 305; Ruiz Austria, 2004; Montiel et al. 2016; Collantes, 2018). As a result of strong advocates for women’s reproductive health and freedom by the women’s movement and civil society, the RPRH act was passed by the government in 2012, ensuring women’s access to contraceptive services in spite of the values of the Catholic Church (Brillon, 2013; Collantes, 2018; RPRH, 2012).

The following section presents the RPRH act and the health system that together forms the structure that provides and enables individuals’ access to FP services.

2.3.2 The Responsible Parenthood and Reproductive Health Act

The RPRH act acknowledges individuals' right to FP services and modern contraceptives (RPRH, 2012; Tanyag, 2015). In accordance to the act, the state is mandated to ensure universal access to safe and affordable contraceptives and information that provides individuals and couples with the ability to have their desired number of children (RPRH, 2012; Parmanand, 2014). While the act ensures individuals' access to FP services, it adopts a rights-based approach in promoting family health and wellbeing (David et al. 2012, 315). It also recognizes the socio-economic barriers that disproportionately affect marginalized groups, particularly poor women, from accessing FP services and contraceptives (Tanyag, 2015). By providing a wide range of FP services to individuals the act sets out to enable them to take an informed choice on a contraceptive method suitable for their life and family goals (RPRH, 2012).

The National Household Targeting System for Poverty Reduction is used to identify poor households (Fernandez, 2012; RPRH, 2012). The system was established to improve the delivery of social services for people living in poverty and has prior to the RPRH act been used to identify households eligible for the national Conditional Cash Transfer program (Fernandez, 2012; DSWD, n.d.). The system helps to identify poor households who are offered the services, e.g. contraceptives, under the act for free (RPRH, 2012).

Responsible parenthood is strongly manifested in the act and refers to the will and the ability of parents to work for the needs and the ambitions of the family (RPRH, 2012, 11). To have such ability, parents are given relevant information to be able to make an informed choice (RPRH, 2012, 5). The act emphasizes the importance of shared responsibilities between parents as such could enable them to determine and achieve their desired family size while taking consideration of their economic and sociocultural concerns (RPRH, 2012). This includes male responsibility, which refers to: "the involvement, commitment, accountability and responsibility of males in all areas of sexual health and reproductive health..." (RPRH, 2012, 8).

While the Department of Health (DOH) has the overarching responsibility to allocate funds and monitor the implementation process of the RPRH act, the Local Government Units (LGUs) are the main implementers of the act locally (RPRH, 2012). The LGUs procure, provide the services and monitor the need and usage of supplies within each district (DOH,

2014; DOH and POPCOM, 2017). Contraceptives are provided at three different levels of the healthcare system. The Barangay Health Stations are the primary healthcare facilities that provide individuals with less complicated contraceptives, e.g. pills (DOH, 2014). At the birthing facilities, midwives perform sterilizations, IUDs and implants (DOH, 2014). In addition to the services provided at the primary healthcare and birthing facilities, hospitals perform sterilizations (DOH, 2014).

2.3.3 Contraceptives under the act

The contraceptives that are available for free under the RP act are hormonal contraceptives, intrauterine devices, injectables and other contraceptives that are affirmed as non-abortifacient (RPRH, 2012).

Individuals and couples living in poverty can through the RPRH act also access information on traditional contraceptive methods at primary healthcare centers (RPRH, 2012). As discussed by authors, traditional methods are associated with higher odds for undesired pregnancies and low levels of effectiveness (Marquez et al. 2017). In spite of this, traditional methods, such as withdrawals, are commonly used among couples, mostly because it is for free and does not require any visit to a healthcare center and thus can be spontaneously used by couples (PSA and ICF, 2018; Marquez et al. 2017). As discussed in Marquez et al (2017), women living in poverty in Metro Manila preferred traditional methods because of the lack of side effects. Table 1 provides a short description of the contraceptives used by the informants of this study, which all are covered under the RPRH act. A more detailed description can be found in Appendix B.

Contraceptive	Description	Access	Usage	Effectiveness
Pills	Hormonal contraceptive. Prevents ovulation.	At Barangay Health Units.	Women orally take the pill every day.	Prevents pregnancies with >99%
Injectable	Hormonal, long-acting contraceptive. Prevents ovulation.	At Barangay health Units.	Women are injected every three months.	Among regular users, prevents pregnancies with >97%
Implants	Hormonal, long-acting contraceptive. Prevents ovulation.	At birthing facilities.	Inserted inside the woman's upper arm. Can be used for 3-5 years.	Prevents pregnancies with >99%
IUD	Hormonal, long-acting contraceptive. Prevents ovulation.	At birthing facilities.	Inserted inside a woman's uterus. Can be used for 3-5 years.	Prevents pregnancies with >99%
Male Condom	Non-hormonal, one-use contraceptive. Blocks the sperm.	At Barangay health units.	Is used for every vaginal intercourse. Is used by the man.	If used properly, prevents pregnancies with >98%
Female sterilization	A permanent contraceptive. A medical procedure. Prevents the sperm from reaching the egg.	At birthing facilities and hospitals.	Performed on the woman's body.	Prevents pregnancies with >99 %
Withdrawal	A traditional contraceptive that keeps the semen away from the woman's genitals.	Barangay health units.	The method is performed at each vaginal intercourse. Depends on male action.	If used correctly and consistently, prevents pregnancies with 96 %
Calendar method	By monitoring the menstrual cycle, a couple can identify days when the woman is most fertile.	Barangay health units.	During the 1 st to the last day of the woman's fertile days, the couple abstains from vaginal intercourse or uses condom.	If used correctly and consistently, the method prevents pregnancies with 91%

Table 1. Contraceptives used by the informants. Detailed information from WHO (2018).

3. The Underpinnings of Family Planning

Building on the previous section, this chapter will provide a conceptual understanding of FP, addressing its history and highlighting the link to women's bodies and gender norms.

Recognizing the width and multiple dimensions of SRH, this section aims to provide an insight to the area by emphasizing its relevance to understand the role and responsibility taken by women and men.

3.1 Population Control

In the realm of SRH, women have remained the main concern even though the approach and the focus have looked different over time. Prior to the International Conference on Population and Development (ICPD) in Cairo in 1994, focus had been directed on how to control and limit population growth (Germain et al. 2015; Lane, 1994). Targeting women's fertility through a top-down approach was inspired by Malthusian ideas that extreme fertility and household poverty is the result of careless couples (Crook, 1996; Hartmann, 1995). Thus, persuading couples to have fewer children was a way to curb rapid population growth (Hartmann, 1995). However, Hartmann (1995) argues that this idea assumes that everyone has similar preconditions and goals while facing the same set of reproductive choices, which simplifies the reality and treats people living in poverty as a homogenous group. It also focuses on symptoms rather than impeding structures that undermines people's abilities in society (Hartmann, 1995). In contrast to this approach, states adopted the definition of SRH brought forth through the Programme of Action (POA) at the ICPD (UNFPA, 2014).

Adopting the concept of SRH shifted the focus of fertility and reproductive health (RH) to women through a rights-based approach (Hartmann, 1994; Lane, 1994; Hadi, 2017). The global community thereby recognized socio-political and economic factors that significantly affect the fertility and RH of women (Lane, 1994). States agreed that women and girls' access to education and FP services were essential building blocks for development and to alleviate poverty (Hadi, 2017). Authors have found that having access to FP services has helped to increase human capital for women and is associated to poverty reduction in low-income settings (Starbird et al. 2016; UNFPA, 2012). Thus, women's SRH is considered the means and the end in achieving a stable population growth, where women, through a rights-based approach, are given the ability to make an informed choice and meet their desired family goals. This approach has come to mirror the continuous work and targets taken on a global level (Hadi, 2017).

Although this shift has created empowering conditions for women in poverty, authors have addressed concerns that population issues remain linked to women's bodies (Bertotti, 2013; Davis, 2017). These concerns will be raised in the following section.

3.2 Feminization of Contraception

It is important to look at the users of contraceptives to further understand the role and responsibilities of women and men. During the last 50 years, the access to and use of modern contraceptives has increased in low- and middle-income countries (LMICs) (Townsend et al. 2011). Between 1970 and 2015, the use of contraceptives almost doubled worldwide from 36 percent to 64 percent (UN, 2015). On a global scale, despite contraceptives also having been developed for men, contraceptives for women dominates the used among couples, with female sterilization and IUD at the top of the list (UN, 2015, 24). This directs attention to the responsibility women take in FP, which in high-income countries (HIC) has been referred to as the “feminization of contraception” (Davis, 2017; Kimport, 2018). The concept is used to explain the unequal burden placed on women to take responsibility over contraceptives, which reflects the inequalities prescribed to it when it becomes gendered (Davis, 2017). As the author highlights, this reflects a power relationship between women and men that derives from gender norms (ibid.). Although modern contraceptives presented an efficient method for couples to regulate fertility, the most common methods, such as Pills, were developed for women (Goldin and Katz, 2002; Davis, 2017). This marked a shift when contraceptive responsibility now was placed on women exclusively (Davis, 2017). Having the primary responsibility in preventing pregnancies is highly time consuming, which authors refers to as “fertility work” and “reproductive unpaid work” (Wiggington et al. 2018; Fennell, 2011; Bertotti, 2013). Bertotti (2013) emphasizes the burdens associated to this responsibility, recognizing extra time, the physicality of side effects and the stress in planning, obtaining and using contraceptives to prevent pregnancies. Although research is mainly focused on HIC, referring back to the global statistics on contraception used among couples, one could argue that similar responsibilities exist across other income settings.

From this section, addressing the underpinnings of FP shows how women's bodies are associated with FP. The gender division of FP also reflects the power relations stemming from gender norms and roles. Therefore, concepts regarding power, gender norms and roles and agency will constitute the theoretical framework as presented in the following chapter.

4. Theoretical framework

The theoretical framework will be used as a lens to analyze the findings of this thesis. Informed by the context of the Philippines and the underpinnings of FP, the framework consists of concepts of power, gender norms and roles, and agency. These concepts are interrelated and together help explain structures and dynamics that shapes individuals' roles and responsibilities. As each of the theories can be seen as a lens that allows us to interpret certain aspects of roles and responsibilities, each will be used to understand the nuances of the findings. Using this framework allows the exploring of both possibilities and constraints of women and men. It helps to understand that roles and responsibilities do not exist in vacuum but instead are shaped by structures in society. However, as theories help to address, the structures are dynamic, which enables us to understand the phenomenon from different angles. First, the aspects of power will be presented, followed by the construction of gender norms and roles. Finally, the idea of agency will be presented to help us reflect on individuals' actions as part of their agency.

4.1 Power

Power can be understood as a process that acts through individuals, groups or states (Tallis, 2012). The power implies having the ability and motivation to force a will on another person, group or nation and maintain that relation (Lukes, 2005). This view on power has been described as “power over” or “traditional power”, reflecting a dominant and a weaker actor or groups of actors where the dominant subject seeks to ensure compliance (Allen, 1999; Rao and Kellener, 2002). However, using binary terms in analyzing power dynamics simplifies the social reality in which the power is used and how individuals are portrayed (Tallis, 2012, 52). In line with this view, Tallis (2012) argues that power is not only about domination but also about experiencing it. This view can help to explain the different dimensions of power (Tallis, 2012, 50).

Foucault argues that power is relational and works between two actors or groups (2000). If one actor holds power over a topic, the other part's power will automatically decrease (ibid.). While Foucault explains power as being exercised by individuals, others argue that power can be part of structures and not consciously exercised by specific actors or groups. Rao and Kellener (2002) use “agenda power” and “hidden power” to address this view, highlighting

how power structures exist and are reproduced in society. On the one hand, although power itself is not created by individuals but rather is the result of social and cultural processes, individuals can use it in strengthening their own position in institutions (ibid.). On the other hand, while individuals can use the structural power, they are also confined to its boundaries (ibid.). The authors describe agenda power as the ability of actors to create and control the agenda of discussions, which for instance influences what topics individuals raise within particular settings or institutions (ibid.). Hidden power refers to such power that affects individuals to comply their perceptions and preferences to match social structures (ibid.). One could argue that these types of power are reflected in structures of gender norms and roles as such are formed in society but are used and reproduced by individuals. The following section will present gender norms and roles more in detail.

4.2 Gender norms and roles

As previously addressed, power fluctuates in society and involves individuals. Gender norms and roles work in similar ways. This section will address how gender is constructed and how it guides and directs women and men in society. As this section will highlight, gender norms and roles are not static but dynamic in the way how it is experienced and exercised by individuals.

To explain patriarchal structures feminist theories address the importance of separating the biological understanding of sexes from the notion of gender (Tallis, 2012). Butler (1999) criticizes binary terms of gender, such as man and woman, and rejects the idea that masculinities and femininities are personalities that are given humans at birth. In contrast to the biological sex a person is born with, gender is socially constructed in society (Butler, 1999; Tallis, 2012; Connell, 1987; Gardiner, 2005). This implies that gender is not the result of sexes or is permanent to it but is independent of sexes (Butler, 1999; Connell, 1987). On a societal level, what is associated with a specific gender is a result of a process, which is developed by individuals' social practices or actions that in turn construct what is associated with the specific gender (Connell, 1987). This means that individuals are both creators of gender and what is associated with it as well as subordinated to it (ibid.). Hence, masculinities and femininities are continuously socially constructed and reproduced in society by individuals (Connell, 2012; Hasan et al. 2015). This relates to Butler (1999) arguing that gender should not be interpreted as a static identity or agency in which certain acts follows but rather as a vague identity founded in time through actions (Butler, 1990, 141). Connell

(1987) explains that individual practices or actions, generating the construction of gender, can be seen as practices in the moment. However, the room or the institution in which the practice is performed persists (Connell, 1987). Similarly, Butler (1988) uses the idea of “performativity” and argues that gender categories, such as male/female, are constructed through performative actions (ibid.). Performative action is the result of social consents and taboos that adversely result in individuals being associated to a specific gender (Butler, 1988). Hence, it is through such continuous practices that construct gender identities. Such identities are not static but are the result of continuous practices, institutionalization of attributes and consent among people, which create gender norms (Butler, 1988). This aligns with authors’ idea that the role and behavior of men and women respectively can be explained as the result of norms attributed to the socially identified gender the person associates the self with, which informs the person on how to act (Blanc, 2001; Fyall and Gazley, 2015). Looking at masculinities, authors argue that despite not all men comply with the masculine norms and roles, they are sustained because of men’s consent of it, i.e. through men’s motivation to support the masculinities and working to sustain such images (Connell, 1987, 299; Lusher and Robins, 2009). This creates a normative structure that gets rooted in society (Connell and Messerschmidt, 2005, 832). Furthermore, this depicts the link between gender norms and roles with power, highlighting how power is used to reproduce and sustain gender norms and roles in society where individuals are both agents and prisoners. Tallis (2012, 55-56) addresses that even in oppressive environments, where individuals might have some power to challenge the structure, this does not necessarily mean that they will do so. Instead the author argues that acting against oppressive power depend on individuals’ internal processes of consciousness and beliefs (Tallis, 2012, 55-56). This is recognized by the idea of agency that builds on the belief that individuals have an inherent power that they act upon, which will be further presented in the following section.

4.3 Agency

While the previous sections have stressed how power structures affect individuals, this section will explain how individuals can resist and experience such structures. This idea will help to understand individuals’ actions in relation to FP.

While the concept of power can be applied on different levels of society, agency on the other hand acts on an individual level. As discussed by authors, the concept of agency can be

viewed as a type of power that an individual person possess and acts upon (Paul et al. 2017; Kabeer, 2012; Hirschmann, 2003). As explained in Paul and authors' study (2017), it entails having the ability to identify and act upon different alternatives in order to reach specific goals.

Kabeer (Kabeer, 2000) uses the concept of agency in explaining empowerment processes. The author addresses the role of power structures in restricting individuals from pursuing their wellbeing and reaching their goals (2000). Kabeer (2005) argues that having power is the ability to make choices. So while disempowerment refers to a person being denied choices, empowerment refers to a process in which a person who previously was disempowered acquires the ability to create choices (Kabeer, 2005). Thus, empowerment entails change where power relations or structures are challenged (Kabeer, 2005; Kabeer, 2012). Having the ability to choose between different alternatives plays a central part in Kabeer's (2005) reasoning. Therefore, in order for it to be considered as empowerment an individuals needs to have alternatives to choose between. Secondly, the alternatives not only need to exist but they also need to be *seen* to exist by the agent (Kabeer, 2005). Similarly to Rao and Kellener's (2012) idea of hidden power, Kabeer (2005) argues that power structures are particularly effective when they are hidden and not perceived as such but instead are accepted and goes unquestioned. As Kabeer (2005) argues, a person's ability to make strategic choices for own good can be constrained as a result of institutional bias that plays out in shape of social norms or gender roles. This can result in a person complying with undermining environments and not challenging constraining powers because to do so does not have to appear possible or can result in social costs for the individual (Kabeer, 2005). Such fundamental structures might be indoctrinated in society, which forces individuals within it to accept them (Kabeer, 2005, 14). Therefore, because of prevailing rules being indoctrinated in society, it affects individuals' choices as well as their ability to act upon their available choices (Kabeer, 2000). Similarly, Hirschmann (2003) draws attention to the importance of using a gender lens on the freedom to choose. By considering how the choosing agent is created and shaped within the context, such circumstances have the ability to form and color the agent's choices (Hirschmann, 2003). Therefore, agency is the power an individual possess but since the individual is part of society where power structures prevail, such as norms and roles, the choices individuals have and see are shaped by such structures.

The theoretical framework presented will be used as a gender lens to shed light on power structures existing through gender norms and roles that are mirrored in society and reflected in individuals' actions, which adversely affect women and men (Gardiner, 2005). The theories presented are guided by a feminist standpoint in understanding the phenomenon of roles and responsibilities. This means that how the world is observed is based on the point the individual who describes it stands, which shapes what the person is able to see (Coltrane, 1989). Such standpoint reflects a person's interests or can be used to understand a person's engagement in matters (Harding, 1987). This way of interpreting the world can tell much about how gender differences and inequalities are created and maintained (Coltrane, 1989). The following chapter will go deeper in the standpoint of this thesis and will present the methods used in conducting this study.

5. Methodology

This chapter presents the methodology used to conduct this thesis.

5.1 Research design

This thesis is guided by a constructivist ontological standpoint as it corresponds to my view on knowledge as being constructed by the observer, meaning that it differs between individuals and time (Moses and Knutsen, 2012, 169). Hence, in trying to understand the role and responsibility of women and men, I will only be able to grasp the informants' subjective perceptions of it. Additionally, this thesis is guided by an interpretivist epistemological standpoint. I believe that the way the phenomenon is grasped is not only constructed by the informant but also interpreted by me as a researcher (Hammet et al. 2014). Therefore, I acknowledge that my previous knowledge, background and experience can have influenced the knowledge produced (Hammet et al. 2014). Because of this, one could argue that the findings are co-produced by the informants and myself, which is why a section of positionality, reflexivity and power has been developed and will be presented later in this chapter (Funder, 2005). Therefore, to have proper knowledge of the context and of the individuals participating is crucial when collecting and analyzing such data (ibid). All these aspects have guided the methodology taken throughout this thesis and will be presented in detail in the following sections.

Guided by a qualitative research strategy, this thesis was conducted using qualitative research methods and analysis. To enhance understanding of the role and responsibility on concerning FP, qualitative research methods were particularly useful as it enabled me to investigate the perceptions and attitudes of women and men (Bryman, 2012; Scheyvens, 2014). Through this approach, informants were able to freely describe their subjective view on roles and responsibilities concerning FP. Focus was given to the informants' language and use of words, which made the foundation to understand the phenomenon (Moses and Knutsen, 2012; Bryman, 2012). Guided by a constructivist way of understanding the social world, this thesis was centered on the perspectives raised by the informants of this study. Their views and ideas forms the main ground for this thesis. In line with the ontological and epistemological standpoints, this thesis follows an inductive approach generating and contributing to theory (Bryman, 2012, 111).

This thesis uses a descriptive single holistic case study design, which allows for a detailed understanding of the role and responsibility of women and men concerning FP (Yin, 2009). This design is very context specific since it helps to describe the phenomenon in the real-life setting where it takes place (Yin, 2003; Baxter and Jack, 2008). The case and the unit of analysis of this thesis represent the role and responsibility of women and men on matters related to FP and contraceptives. To understand the role and responsibility, it was particularly important to incorporate the views of both women and men as they both can shed light on the role and responsibility taken within heterosexual couples, which could give a more nuanced understanding of it (Baxter and Jack, 2008; Flybjerg, 2006). If only women would be interviewed, only their perspective of the phenomenon would be incorporated and could thus make a more incomplete understanding of the phenomenon (Dumez, 2015). As such, the interviews constitute the primary source of data constructing the case of the thesis and will play the main part in the analysis. Additionally, a literature review was conducted to inform me in the process of developing the research focus, identifying the research gap, as well as to contextualize the case itself in finding key concepts (Hammet et al. 2014). Lubsearch and Google Scholar were the main search engines used to find peer-reviewed, scientific articles. Various keywords and combinations of keywords related to FP and SRH were used to find relevant articles. Even though some authors argue that using more data sources is the trademark of case studies as it provides a deeper insight on the phenomenon, the decision to focus primarily on the perspectives of women and men was deliberate as it aligns with the purpose of this thesis, i.e. the subjective perspective of women and men (Yin, 2014; Baxter and Jack, 2008).

5.4 Sampling and Data Collection

The data of this thesis was collected in Bagumbong and Batasan Hills, which are two urban communities in Metro Manila. Metro Manila constitutes of 17 cities surrounding the capital and represents the most densely populated urban area in the Philippines (PSA, 2016; NEDA, 2011). Because of the high influx of domestic migrants, the pressure on housing and tenure has increased and in turn created large informal settlements across Metro Manila, including in Bagumbong and Batasan Hills (Morin et al. 2016; Almaden and Navarro, 2016; Lara et al. 2017). Batasan Hills is one of the Barangays (municipalities) with the largest informal settlements in Quezon City and Bagumbong in Kalookan City is also characterized by high numbers of informal settlers (Cabalfin, 2014, 159; Cruz, 2010). In the Philippines, informal

settlements refers to individuals who without formal permission of the land owner has constructed houses that does not follow local guidelines, regulations and plans for building (Reyes et al. 2012). Even though not all informal settlers are income poor, informal settlements are often associated with overcrowded neighborhoods, insufficient housing standard, and inadequate access to safe water and sanitation (Ballesteros, 2010). Informal settlements are also characterized with poverty (Ballesteros, 2010; Chikiamco and Fabella, 2011; Choi, 2016). Approximately 32 percent of informal settlers are living in poverty with an income of less than 20 000 Philippine Pesos (USD 400) annually per capita and 12 percent lives in extreme poverty with less than 1.25 USD per day (Ballesteros, 2010). In Bagumbong and Batasan Hills a large number of households are income poor and enrolled in the national cash transfer program ¹(4Ps).

In order to gain access to women and men in poor urban communities, various gatekeepers were initially contacted (Bryman, 2012). After contacting the Women's Global Network for Reproductive Rights, I was further introduced to their local partner, Woman Health, which in turn was engaged with local community organizations in Metro Manila. Bagumbong and Batasan Hills were selected as data collection sites because of their geographical location, the local staff being able to assist me in the field, and due to the majority of the inhabitants being poor urban settlers. The informants of this thesis were identified using a mix of purposive and snowball sampling strategies (Bryman, 2012, 418). In line with the purpose of this thesis, heterosexual women and men between 18-49 years of age, residing in poor urban settlements were searched for. In Batasan Hills, the local community workers were informed of the criteria and could therefore make contact with suitable informants before I entered the field. In Bagumbong, the local community worker introduced me to one informant who in turn helped me identify the next informant fitting into the criteria and so on. Because of the sample being developed through social contacts, the strategy did not provide a representative selection of informants (Bryman, 2012). However, in line with the purpose of this thesis, the sampling strategy was suitable to explore the role and responsibility of women and men.

In total 16 informants were interviewed, of which 9 were women and 7 were men. Due to convenience for the informants, the majority of the interviews were conducted in the homes of the informants. In Batasan Hills, one interview was conducted at the Barangay station and

¹ Luisa Lentejas at Woman Health, Interview February 7.

two at the local organization's daycare center. Because of the sensitivity of the research topic, all informants are kept anonymous and been given a pseudonym for this thesis. When referring to an informant, their changed name is used.

Table 2 shows a detailed description of the informants. As seen in the table, there are variations in age, marital status, number of children, and contraceptive methods. To note, the majority of the female informants were housewives. While the majority of the informants were in a stable relationship, two informants were single but were engaged in sexual relationships. The latter were included in the data because of their ability to shed light on their view on contraceptives as well as on their role and responsibility over it. Additionally, Angel and Sean were married to each other. They were both individually interviewed and their views were treated as the rest of the data.

Interview	Name	Sex	Age	Marital status	Nr of children	Place of residency	Occupation	Contraceptive
1	Ofelia	F	30	Married	2	Batasan Hills	Housewife	Traditional methods
2	Christine	F	33	Stable partner	5	Batasan Hills	Laundry worker	Injectables
3	Maria	F	43	Married	5	Batasan Hills	Housewife	Female sterilization
4	Sandra	F	24	Married	2	Batasan Hills	Sales assistant	IUD
5	Ryan	M	38	Stable partner	3	Batasan Hills	Chef	Calendar method
6	Patricio	M	42	Girlfriend	1	Batasan Hills	Restaurant/dining	Condoms and withdrawals
7	Michael	M	26	Stable partner	1	Batasan Hills	Construction work, plumber	Pills
8	Rodrigo	M	25	Single	0	Batasan Hills	Freelancing artist	Condoms and withdrawals
9	Raymond	M	23	Single	0	Batasan Hills	Window cleaning and tattoo artist	Withdrawals
10	Angel	F	32	Married	2	Bagumbong	Housewife	Withdrawals
11	Sean	M	33	Married	2	Bagumbong	Factory worker	Withdrawals
12	Alex	F	29	Stable partner	3	Bagumbong	Housewife	IUD
13	Luisa	F	26	Married	1	Bagumbong	Health worker	None ²
14	David	M	22	Stable partner	1	Bagumbong	Delivery helper	Injectables
15	Michelle	F	38	Stable partner	3	Bagumbong	Housewife	Injectables
16	Joanna	F	37	Married	5	Bagumbong	Housewife	Injectables

Table 2. Description of informants.

² Luisa was trying to get pregnant.

The data was collected during three Sundays between January and February 2018. The fieldwork was conducted during Sundays because for many it was the only day of the week the informants' were free from work and other chores. Even though the official language in the Philippines is English, not everyone is fluent. To enable the informants to express their thoughts and opinions, I used an interpreter who could translate from Tagalog to English during the interviews. I used a different interpreter for each Sunday. The interpreters were either students or were newly graduated from university with experience from conducting interviews in similar settings before. There is a risk with using non-professional interpreters, as they might not be fully able to translate the interviews correctly or specifically. However, these risks were minimized as they were all bilinguals, had read the interview guide prior to the sessions, and were well informed on the research topic. Because of the use of interpreters, the data of this thesis is paraphrased, which could have influenced the analysis.

In order to explore the role and responsibility of women and men on matters related to contraceptives and FP, semi-structured interviews were conducted using the interview guide in Appendix A. The qualitative interview method was suitable because while it focuses on specified themes, it gave room for the informant to develop her/his views, which enabled an in-depth understanding of the interviewee's social world (May, 2011). The structure also allowed flexibility in moving away from the interview guide to explore topics raised by the informant, i.e. to follow up on topics, asking sub-question to clarify or encourage the informant to elaborate the answer (Bryman, 2012, 471; May, 2011). An interview guide was developed that covered specific topics related to the research questions. The wording and the order of the questions posed were formulated to suit the female and male informants (Bryman, 2012, 471-473). Social characteristics were collected from each informant that included their name, age, gender, employment, children, marital status and contraceptive use, which was useful information when contextualizing the data (Bryman, 2012, 473). As I did not conduct any pilot interviews, the first interviews and encounter with the communities helped me to familiarize myself with the community and adapt the questions (Bryman, 2012, 473).

With oral and written consent (see Appendix C), all interviews were audio recorded and transcribed. Not having to think about the audio recording helped me to be fully present during the interviews and to pose relevant follow-up questions that gave meaningful answers (Bryman, 2012, 475). The recordings and the transcriptions helped me capturing the whole

interview and to examine the words and meanings expressed by the informants (Bryman, 2012, 482). The transcripts were made in Word and were properly stored to ensure the informants' anonymity. By manually transcribing the data, I was able to refresh my memory on the interviews. Data saturation was achieved when no new themes were raised and emerged during the data collection (Grady, 1998; Saunders et al. 2017).

5.5 Data analysis

The primary sources of data are interviews and transcriptions. When the transcribing was done, I read through the material several times to get more familiar with the findings. The transcripts were coded through a two-step way using Nvivo and Excel. The Values Coding Method guided the first round of coding. This coding strategy focuses on understanding the informants' values, attitudes and beliefs (Saldana, 2009, 89). The method is based on a careful coding analysis of transcripts where the informants' ideas of oneself, someone else, something or a general belief are explored (ibid.). Through this approach I was able to go in-depth in understanding their view on matters concerning women's and men's role and responsibilities on FP. This method was also useful to understand how roles and responsibilities are rooted in gender norms and roles and helped to understand the agency of individuals. The method helped to filter the findings to focus on matters related to the purpose of the thesis.

Words or longer sentences in the transcripts were coded based on whether it was a) an attitude: the way the person thinks and feels about something, someone or oneself, which are affective reactions on matters based on beliefs, b) a value: how something, someone, or oneself is given an importance, or c) a belief: which is part of a system that involves both values and attitudes but also "personal knowledge, experiences, opinions, prejudices, morals, and other interpretative perceptions of the social world" (Saldana, 2009, 90). In coding attitudes, the codes were centered on how the informant used the self to explain the statement in which most attributes circulated on the use of "I", referring to a person's own experiences, thoughts, and feelings. To be coded as a belief, the informant had expressed a general belief she/he had. Finally, a value was coded when the informant emphasized the value of something or a person for the informant her/himself.

Nvivo was used for the coding process. Each interview transcript (N=16) was entered and classified by sex (M/F). Each transcript was coded manually where the informants' answers

were coded based on Values (V), Beliefs (B) and Attitude (A). While some of the codes were unique, meaning that only one person had expressed such opinion, other codes were represented by several informants. After controlling that all codes were made correctly, in line with the criteria for the Values coding, the codes were divided into three categories: values, attitudes and beliefs.

By using Excel, the second round of coding was conducted. The codes within each category were grouped into larger themes. Similar codes such as “Trust in natural methods” and “Trust using method” were merged together due to similar content. While this method helped larger themes and patterns to emerge, it also enabled a process making sense and meaning of the data (Saldana, 2009). Thus, the coding process enabled exploratory understanding of the findings that enabled to conduct a rich analysis based on linkages rooted in the data (Saldana, 2009).

The strategy of the data analysis placed the perspectives of the informants in the center of the analysis. The theoretical framework was then used to explain and make sense of the findings. Therefore, the analysis goes in line with my constructivist standpoint. Also, the coding process builds on an interpretivist way of making sense of data as it builds on how the informant interprets her/his understanding of roles and responsibilities and by me as the researcher, interpreting the finding and coding it.

5.6 Ethics, Positionality, Reflexivity and Power

Collecting primary and sensitive data through interviews with female and male informants in poor urban settlements required various ethical considerations to make sure that the informants were respected and protected from harm during the whole data collection process (Ragin and Amoroso, 2011, 89).

Each informant was given a short oral introduction to the thesis, where I highlighted why I wanted to incorporate their views, and how I planned to use their shared reflections (Bryman, 2012, 138). During my introduction I strongly emphasized the ethical principles that guided me. These were principles such as informed consent to participate and for audio recording (both written and oral), participation is completely voluntary, the freedom to stop the interview at any point, to decide not to answer any particular question, and ensuring the informants' anonymity. All these principles were integrated in the interview because of the

sensitivity on the matter and my intentions to create a safe environment for the interviewees (Hammet et al. 2014). Even though qualitative interviews are structured to shift the power structure, giving more room and ability for the interviewee to direct the interview, I am aware of the power that still exist with me in the room (England, 1994; Sultana, 2007). As pointed out by England (1994), to avoid exploiting informants on information for own purposes, I tried to assure these ethical guidelines to respect the integrity of the informants. For instance, this was done by informing the ethical guidelines and asking the interpreters to sign a confidentiality form prior to the interviews, and being present and alert so signs and body language expressing insecurities were highlighted. The informants' written consent was collected prior to the interviews.

As the findings of this thesis are based on interviews through personal encounters with informants from low-income settings, it is of great importance to acknowledge the asymmetrical power inherent to this type of research and discuss reflexivity and positionality (England, 1994; Funder, 2005; Scheyvens, 2014). Thus, the following section will raise concerns related to the role and background of me as a researcher and the power dynamic that exists.

Being a female white student from a European country and conducting research as an outsider in a poor urban community there are asymmetrical power relations and privileges to take into account (England, 1994; Funder, 2005). Despite the informants' consent to be interviewed it is important to note that consent might have been given because of my characteristics and not entirely because of their own interest. Interviewing on informants' day off implies imposing on their limited free time to participate in something that does not give anything particular in return. This reflects the unequal power relations that exist between the informants and me as a researcher. Being reflexive guided me during the research process. For instance, conducting semi-structured interviews was a conscious choice as it allows the interviewee to decide what to share, which can be seen as shifting power to the informant (England, 1994). For me, I wanted to avoid exploiting the informants for information and instead focus on collecting good data (Hammet et al. 2014). Guided by feminist research strategies (England, 1994) I adopted a supplicant role during the interviews, meaning that in trying to build rapport with the informants it was important for me to be respectful to the informants' stories, and to listen patiently and stay alert for them. Through this approach, my aim was to address the unequal

power relationship associated with this type of research. Additionally, this strategy also helped me to approach the data and to understand the informants' perspectives better.

One cannot deny that my background is different from the informants' and that such can make it difficult for me to relate to and truly understand the complexity of their reality (Sultana, 2007). However as Sultana (2007) addresses, the knowledge gained through research processes is the result of the context, power relationships and the positionality the researcher undertakes to gain knowledge. This implies that the findings are partial, directing attention to how the knowledge is created as the result of the context and relationship of the researcher and the informant (ibid.). Adding to that, representation and its impact is also relevant in this discussion (Ragin and Amoroso, 2011). While sampling strategies influences which voices and perspectives are represented in the study, the way that findings are presented lies with the researcher, which again directs attention to the asymmetrical power over research (Ragin and Amoroso, 2011). However, to involve marginalized individuals, who's perspectives are rarely represented or mainstreamed, is a way in giving a voice to them and improve the representation of them as a group (Ragin and Amoroso, 2011).

5.7 Trustworthiness

This section discusses the trustworthiness of this thesis. The four criteria that constitute trustworthiness help to assess the quality of qualitative research (Bryman, 2012, 390). Applying the credibility criterion of trustworthiness, this thesis shows both strength and weakness. In terms of conducting the research in accordance of good practice this thesis has applied various ethical considerations throughout the research process. Due to lack of time and resources, a member validation was not conducted, which otherwise could have helped ensure the findings were interpreted and understood correctly (Bryman, 2012, 390). Hence, the credibility of the findings can be questioned to some extent. However, through data analysis similar ideas were found across informants' answers, which could be seen as a type of triangulation that confirms and strengthens the findings.

As a qualitative study, the transferability of the findings of this thesis is low, especially since the findings are based on a small sample restricted to two specific geographical areas and time when it was conducted. It is also crucial to take into account how the researcher- informant relation shapes the findings and therefore could not be transferred (Scheyvens, 2014; Sultana, 2007).

In terms of the dependability criterion, the findings of this thesis has not been audited by peers, which otherwise would have justified the analysis of it (Bryman, 2012, 393). However, the methodological discussion has been developed to, in a transparent manner, shed light on the whole research process, which could help to justify the findings of this thesis.

Finally, to meet the criterion of confirmability is of particular importance as it helps to demonstrate that the findings derive from the informants and not from own biases (Shenton, 2004; Bryman, 2012). To strengthen the confirmability criterion of the findings, the informants' own words have remained in focus throughout each step of the research process. The perspectives raised in the analysis emerged from the Values coding that initially was conducted. While this coding method helped to highlight the informants' values, attitudes and beliefs, it also formed the basis for the second round of coding in which the theoretical framework helped to explain the findings through the themes that had emerged from the first round of coding. Also throughout the analysis, rich quotes have been used to exemplify and discuss the findings, which also has helped to demonstrate how the interpretations of the findings and the conclusions were made (Cope, 2014).

5.8 Limitations

Before presenting the findings and analysis of this thesis, a few limitations need to be addressed. The limitations of this thesis relates to the sample and the sampling strategy as well as the language barrier during the data collection.

There are issues of selection bias and representativeness with purposive and snowball methods (Bryman, 2012; Creswell, 2012). The two data collection sites were chosen because of safety, the availability of local personnel in assisting, and the convenience in reaching them. Even though the two areas were relevant for the purpose of this thesis, the findings might have looked different if data had been collected in other areas. Second, using a local organization to find informants could also be a risk for sampling bias and representativeness. Guided by the inclusion criteria, the organization found potential informants that they found eligible for the purpose of the thesis. Therefore, there is a risk that the informants found had some previous connection to the organization, i.e. being involved or knowing the personnel. Hence, individuals without contact to the organization might not have been reached and therefore excluded from participating in the study. This raises concerns of which voices were

not included in this thesis (Ragin and Amoroso, 2011). Correspondingly, being informed about the purpose of the thesis, the informants who participated could have been individuals who found it easy to talk about SRH, which in turn could imply that the sample is not representative of the range of individuals. Despite this, by looking at the findings and the different perspectives raised addresses the diversity of the sample.

The second limitation of this thesis concerns the language barrier. Not being able to use the same language to communicate with the informants and instead having to use an interpreter to understand the role and responsibility of women and men on matters related to contraceptives and FP is a clear limitation of this thesis. Despite the interpreters' skills in translating the interviews, the depth of the perspectives of the informants might have been lost because of the interview methods (Hammet et al. 2014, 151). Even though all interpreters were introduced to the topic and was familiar with the interview guide it is questionable if the nuances of the informants' language were captured. Thus, because of the paraphrased data, it also affects the result of the analysis.

6. Findings and Analysis

Based on the interviews with the informants, this chapter presents the main findings and analysis of this thesis. The theoretical framework is applied and continuously used throughout the chapter to further understand the informants' roles and responsibilities on matters concerning FP.

6.1 A Woman's Body, a Woman's Concern

In understanding the role and responsibility of women and men, the following section is centered on women's role on matters to FP. The findings are discussed by using perspectives on gender norms and roles.

The majority of the informants address that being a woman and a mother entails a range of responsibilities, which also creates the ground for a woman's role in matters related to FP and contraceptives. Rooted in the biological possessions that the female body pertains, specifically referring to women's ability to give birth, informants address the responsibilities assigned to women in controlling and limiting childbirth. As addressed by male informants, Sean argues: "[....] we're not really interested in it [contraceptives]...because men don't really talk about it cause men don't get pregnant". By using 'we', Sean emphasizes his belief that men are not interested in matters to contraceptives simply because men are not the ones bearing the child. By saying this, Sean makes a clear distinction between men and women. Because of a woman's ability to get pregnant, Sean believes that talking about controlling and limiting childbirth is seen as a matter for women only. Similarly, Luisa addresses the role and responsibility assigned to her by her partner: "Based on my experiences like my husband don't go with me [to the healthcare center]. He tells me that it should be me who is going there because it is [contraceptives services] for me and I'm the woman". Luisa's experience, shed light on the responsibilities assigned to women because of their biological sex. Despite the ability to give birth it poses questions to why controlling childbirth should only be the responsibility of women? Especially since a woman is not born with an intrinsic responsibility of making sure to control matters to contraceptives. Even though women are assigned and take responsibility over contraceptive matters, it does not instinctively mean that women chose this responsibility but that it was given to them because of their gender. To understand

women's role and responsibility better, the following paragraph will apply perspectives on gender norms and roles.

The belief and experience shared by informants that women should bear the main responsibility over contraceptives directs attention to a social construction of the female gender, which in turn has formed an identity women and men identify and associate women with. Not only does the constructed role direct women on what to do and what is expected of them but it also reflects what is associated to being a woman. As a result of all female informants taking the main responsibility and the majority of the male informants affirming it, one can argue that such responsibility is constructed as part of the female gender identity. By taking responsibility over contraceptives, women give their consent to the female identity. As a result, women become creators of the gender role and what is associated with it while being subordinated to the role given to them. The constructed female gender thus guides women on what to do and what is expected of them.

While women's actions, taking responsibility over matters related to contraceptives, can be explained by gender norms and roles guiding them on what to do, it raises questions on men's behavior and role in the matter. The following paragraph applies the idea of 'power over'. To understand men's belief that women should bear the main responsibility over contraceptives, can be discussed as a way of men using 'power over' women. Being absent in matters to contraceptives can be argued as the motivation among men to assume women to take the main responsibility over contraceptive matters. Assigning such responsibility can be argued as men forcing women to take responsibility over it and thereby holds 'power over' women. In line with this, having women taking the main responsibility in controlling contraceptive matters could be argued as the result of women accepting their weaker role. Using this idea of power implies a stronger (man) and a weaker (woman) actor. However, this way of analyzing the role and responsibility over contraceptives gets skewed and fails to capture the different types of power fluctuating and influencing the individuals within it (Tallis, 2012). A closer look on the matter helps to address other interesting aspects of power. By zooming out from binary actors of power to focus on how individuals and groups are resisting and experiencing power can help provide us with a more nuanced understanding of the role and responsibility of women and men. Thus, the following section will use the other concepts of power part of the theoretical framework to shed light on power dynamics that exists within institutions and that in turn affects individuals within it.

6.2 Women's Control and Fertility Work

Having the main responsibility over contraceptives implies various tasks. The following section addresses the women's experiences and problems associated with having this role and responsibilities and how we can understand it using perspectives of gender norms and roles, agency, and power.

The majority of the female informants use modern contraceptives (N=6), which involves injecting, taking or correcting something with the female body. This requires regular visits to healthcare centers. To ensure the effectiveness of the modern contraceptives, many require continuous action. So, despite contraceptives are accessed for free, the majority of the female informants address problems and concerns related to obtaining the contraceptives. While some raise problems with regulations at healthcare centers that urge women to be a jour with, others raise problems with stocks.

So for me it is hard [to access] because usually they run out of stock so I have to be there [healthcare center] early to get the contraceptives. If I'm late I have to buy. There is a quota on how many people can get [contraceptives]. So, usually I go there very early to get the contraceptives (Christine).

Having the main responsibility on contraceptives requires women to be proactive. As Christine stresses, having the responsibility over contraceptives also means making sure to avail it. Because of the risk for running out of stock, many of the female informants has to make sure to be at the healthcare center in time to avail the free ones or else women have to buy. Because of the practices associated with the responsibility over contraceptive matters, women find different ways to respond to it.

I was supposed to go back on the 7th for my other dose but then it's already the 11th and I haven't gone back because I'm experiencing some side effects, like my tummy's growing. And since my husband isn't here anyway, I decided it's ok to stop for now [...] (Joanna).

Having the main responsibility over contraceptives gives Joanna control over it. She is the one deciding whether it is good for her and whether to stop using it. Having the control over contraceptive matters enable women, like Joanna, to make strategic choices to enhance own health. Similarly, Alex explains why she chose IUD as contraceptive method: "Most

specifically it's what I use because I don't have to think if I have taken the pill, there's nothing I have to intake. So it's already there and I don't have to think about it anymore". To opt for an IUD can be argued to be a strategic choice taken to ease the burden women in general experience in having the main responsibility over matters on contraceptives. As Alex explains, since the IUD is already there, she does not have to think about it or to regularly visit the healthcare center.

Having the control over contraceptive matters is also associated with seeking information about the different contraceptive methods available. Since most modern contraceptives affect women's bodies, many female informants express a worry for side effects. This is noted in how the majority of the female informants constantly seek information, support, experience and advice from healthcare personnel and close female friends and family members. For instance, Joanna explains: "[...] it gives you a relief that you can actually talk to them [friends] about it [contraceptives] [...]. We usually just talk about what they use, what I use, what are the effects for them and the advantages and the disadvantages of what we use". To seek information and experiences from professionals and other women gives Joanna and other female informants comfort while it increases their knowledge on different contraceptives. Thus, it becomes an important source of information and support for the female informants.

Having the women's experiences in mind, one could argue that the inherited responsibilities urge women to be proactive, gives them control, and encourage them to seek information on contraception. Having this control can be argued as a form of individual power women possess, which enable them to stop using it and to look for better alternatives. Kabeer's (2000) concept of agency can be used to describe how this role and responsibility is a form of individual power. Individual power lies on the agency of a person, being able to identify alternatives and make a choice that will help the person reach own goals. To see contraceptives as alternatives for women, we could use this concept to discuss women's individual power and agency. Having the sphere of control over contraceptives enables women to use their individual power to pursue the wellbeing of themselves. In fact, it can be argued as women are using or acting on their agency when they are a) being proactive: by continuously being a jour with regulations and avoiding lines at the healthcare center, b) in deciding when to stop and switch contraceptive method: to opt for an IUD as it reduces burdens, and c) in seeking support and information: to continuously be updated on contraceptive methods and effects. Thus, the control in being able to choose between

contraceptive methods to achieve wellbeing is a form of power the women possess and use strategically. However, this power cannot be mistaken for an empowerment process since such implies that power structures are challenged. In this case, women are alone in dealing with contraceptives and their role in it is taken for granted. Even though they are able to pursue their own health and wellbeing in choosing a contraceptive that fit their needs, one cannot say that women are empowered in this matter. On the contrary, women act upon the alternatives they perceive but the choices they have are part of a power structure. Women's responsibilities or choices are shaped within the structure that colors their actions. Thus, choosing this or that contraceptive does not challenge the overarching power structure but aligns to it. In fact, women's continuous engagement in contraceptive matters: visiting healthcare centers, obtaining contraceptives, making sure to be there in time to avail it for free, seeking information from personnel and friends etc., can be argued as performative actions. Performing these actions can be explained as the result and the continuous process of women giving their consent to the norms and roles inherited to them as being women. Through the actions, the women themselves create the female gender and the traits or the responsibilities associated with it. Knowing what is expected of a woman makes women subordinated to the norms and role associated with the female gender. Thus, the choices women make are institutionally biased, created within the structure itself.

Kabeer (2005) highlights that individuals complying with undermining societies can be the result of institutional bias, which are played out through norms and roles. Being a woman in this context is associated with a number of gender roles and norms, which in turn assigns women with a number of responsibilities. Women comply with the role associated to their gender and take the responsibilities necessary to make sure the couples have a suitable contraceptive method. By choosing one contraceptive over the other can thus be understood as a woman's power and ability to choose a better alternative for her own wellbeing. But to make a strategic choice that would challenge the power structure the woman belongs to would be something else. Hence, one could argue that women's choices are biased and constrained to the institution in which they live. Because gender norms and roles are indoctrinated in society, women have accepted them without questioning them. To question them would most certainly be associated with social cost or might not even be possible because the role and responsibilities of women has become the normality. Instead the female informants comply with their role as being the one with the main responsibility over matter to contraceptives.

6.3 The Power Dynamic Over Contraceptives

Gender norms and roles can be used to understand the role and responsibility women take on matters to FP. By applying the perspectives on power helps to dig deeper in understanding the involvement of women and men.

Both female and male informants highlight that work hinder men from being able to accompany their partners to the healthcare center. Correspondingly, Sean informs: “The healthcare center is not open on Sundays and my only break is on Sundays”. The majority of the female informants are housewives, directing attention to the role of the men in the household presumably being the main provider of the family. As a result of men’s work, women are left to take responsibility over FP. For instance, Luisa argues: “Mostly it is the women who go there [healthcare center] because usually the men are at work so it is just usually the women who go there [...] Like he always tells me that he is busy so he can’t accompany me”. Men’s work is clearly a barrier for men to take responsibility in this matter. Interestingly, the female informants with jobs still take the main responsibility over matter related to contraceptives. This poses questions to why women take this responsibility. Applying the theoretical perspective of hidden power is useful for this discussion.

Consenting to norms and roles associated with being a woman, can be discussed as the result of hidden power. The hidden power makes women comply with the norms and roles in taking the main responsibility over contraceptives. While hidden power affects women’s role and responsibility, one could also argue that it simultaneously affects men, who are expected to be absent because of work and other duties and thereby complies to norms and roles to match the social structure. Similarly to Luisa, Christine argues that men usually don't care which type of contraceptive method to use, which results in women having to take this responsibility. Christine explains: “With men they just don't care. They don't really have a say in it [contraceptive methods]. They just say ‘go ahead, go ahead!’ so it’s really the women who take care of their bodies and has to deal with their bodies”. Because of men’s lack of concern on the matter, women feel a need to take care of matters to contraceptives to make sure the couple uses protection. As a result of women’s role and responsibility in the matter, men’s role simultaneously decreases. Such dynamics can be understood using Beauvoir’s view of power explained by Butler (1988). With women having the main responsibility in matters to contraceptives, knowing of different types of contraceptives, side effects and where to obtain them, places them on a position with lots of power in this matter. Because of women’s role

and responsibility, the role and responsibility of men decreases, which includes their power and control in the matter. Because of women's work and knowledge in the matter, there is no need for men's involvement in it. Instead, men can rely on women's activeness in the matter to make sure that the couple's fertility goals are achieved. This directs attention to how the role and responsibility in matters to contraceptives is dynamic and relational, just as Beauvoir's reflections on power. This means that the role and responsibility of the two partners is settled because of the power balance between them in this particular matter. At the same time, we can see both actors using the power. For instance, women having the control over contraceptives but still are confined to the responsibilities and men being ignorant and absent, using the norm to avoid responsibilities. However, this does not make men powerless in this matter. Maria shared with me her husband's reaction when she told him she had performed a ligation (female sterilization).

So my husband was ok with contraceptives but with the ligation he was not ok. At the hospital for the ligation I needed my husband's signature [to perform it] but the doctor felt pity so they went through with it [without the signature]. My husband was angry for a while but now he is ok with it. He didn't like that he didn't have control.

Even though it seems like women have power controlling contraceptives, by referring to their role and responsibility, it does not necessarily mean that they have power over it and that men are powerless in the question. In fact men can still have power and are involved in the matter. This is particularly highlighted in Maria's story. Needing the husband's signature to perform a ligation is a clear example of women not having sufficient power to independently choose what is best for her or act upon own matters to reach wellbeing. Adding to that, male partners might still be involved in some aspect of the choice or limiting the choices available for the women. For instance, Maria shares her experience why she decided to use Pills before performing the ligation.

I get pregnant easily and if I didn't use Pills I would have kids right after one another. So pills are the best for me. For the injectable I believe that you get fatter, and that you don't have your period. IUD I think it is scary because it get left inside of you and with condoms my husband doesn't want them.

For Maria her choices were already limited before she opted for the pills, not only by her own preferences but also because she complies with her husband's preferences. Maria is not unique in this case. Involving the husband in the discussion on contraceptives and FP is something that all female informants experience and something that male informants highlight. Sean explains: "Because couples usually talk about what's better, what are the benefits of using it [contraceptives] so they have the same opinion on it because they usually talk about it". This finding directs attention to men's involvement on matters to contraceptives and FP. Even though the responsibility in obtaining the contraceptive method falls on women, through conversations between the partners, the couples talk about the different methods available and agree on a method that suits them. For instance, to use traditional contraceptive methods was a decision made because of the experienced side effects Angel had from using injectables. Having a discussion about experiences, the male partners become aware of women's experiences, which one could argue is a reason for them sharing opinions on contraceptive methods, which Angel addresses: "The decision [to opt for traditional methods] was both ours because my husband understands my situation". So even though women are the ones in control of obtaining and taking responsibility over contraceptives, their male partners are involved in the matter to some extent, referring to preferences or for concern. For instance, Michelle explains. "The schedule for injectable is on Tuesdays and my husband has to go to work so it's usually just me who goes but he knows that I go. There are times when he follows it up with me, that I should go". Because of the contraceptive method of the couple (injectable), and because of the working hours of the husband, Michelle alone takes the responsibility in visiting the healthcare center. However, because of their discussions on the matter, her husband is aware of the method, which makes him involved in the matter by following up if she has visited the healthcare center. This directs attention to the role of men in FP.

6.4 Male Confidence and Vulnerability

Previous sections have shed light and discussed women's role and responsibilities. Despite female informants experience of involved and concerned husbands, incorporating the male informants' perspectives, the role and responsibility of men are minimal on matters to FP and contraceptives. Using perspectives raised by the male informants, the following section will discuss men's involvement in this matter by applying a discussion on masculine norms and roles.

In contrast to women, the male informants are alien to seeking support and information on contraceptives and FP. While some consider talking about contraceptives and FP improper and private, others argue that such information is invaluable to them. For instance, Patricio explains why he never talked to anyone about FP: “For me nothing, no one really because I have an idea on how to do it for FP”. Similar to Patricio, many of the male informants explain that they do not need to talk to anyone about FP and contraceptives, mostly because they are confident with their own knowledge and experiences on the matter. This raises concern to prevailing masculine norms that guides men on how to act and do, which they also consent to through their actions. To exemplify Raymond argues: “So we don't really talk about it [contraceptives]. I just feel like as a man it is just natural what you should do”. Similar to Raymond and Patricio, many of the male informants find talking about contraceptives and FP unnecessary as they find the knowledge about it natural for men. To know what to do when it comes to FP and contraceptives guides men in matters to contraceptives and FP, which makes such information unnecessary. This aligns with previous research on masculinities and the macho-culture in the Philippine, seeing men as independent and strong. Because of these prevailing norms and roles that enroll what being a man is referred to, one can argue that it guides men on how to act and behave with others on matters concerning contraceptives and FP, which the next paragraph exemplifies.

The majority of the male informants have not visited a healthcare center or talked about SRH with friends. For instance, Ryan explains: “As men, I think it is different for women but for us men we talk about... We just joke around. We don't talk about that [contraceptives and FP]. We just talk about light topics”. Not only is talking about matters to contraceptives and FP unnatural, but when approaching such topics men respond to it by jokes. Instead among Ryan's friends they talk about light topics, avoiding topics related to FP. This could be the result of an agenda power that informs men on what topics are acceptable to talk about among their friends or in rooms for men. Because of the gender the men associate themselves with, it also guides them on how to act and behave, including what topics to talk about and to behave around other men. Because of prevailing masculine norms, makes men incapable of talking about topics related to contraceptives and FP. To avoid or joke it away, men comply with the masculine norms. This further means that their perceptions and preferences are matched and imprisoned within the hidden power of masculinity. Power is not created by individuals but rather through social and cultural processes. In this case, one could argue that men's inability to talk about it is a result of men's continuous performative actions that guides them in rooms

with men. Adding to that, to joke on matters related to FP could be explained to be the result of the taboo related to it. Thus, asking for support or for advice becomes a taboo for men, which results in them not being able to talk to others about it. These performative actions can be seen as men give their consent to the masculine norm that guides them on what to do and what is not accepted to do. These actions and consent continue creating the image of the man, being knowledgeable, independent and strong and not in need of information. Thus, the men become the creators by continuously consenting and shaping the masculine norm and role, while also being prisoners to the hidden power. Men's inability to talk about contraceptive matters, except through jokes, reflects a hidden and agenda power where the masculine norms have been indoctrinated in society and within institutions. Complying with norms to match social structures is a form of hidden power that also shapes men and their actions, which makes them institutionally biased. To act differently could be associated with social costs or could be impossible as it would be questioning the self or their manhood.

As a result, men exclude themselves from the services and support available. Many of the male informants have never visited a healthcare center for matters related to contraceptives and FP. The younger are unaware of which contraceptives are available, and some search for information online. This prevailing power structure hinder men from being able to seek support on matters related to contraceptives and FP or from accessing information that could help enhance their SRH. One could also argue that such masculine norms and roles also stops men from taking increased responsibility, especially since most men lack of concern to FP and are ignorant in the matter when being in a relationship. Because of prevailing structures, men distance themselves from being involved and taking more responsibility on matters to FP. Not only does it creates pressure and unequal burden in taking responsibilities on women but it also limits men's ability to get informed and to be more responsible by taking a larger role in matters to their and their partners SRH.

7. Conclusions

This thesis sets out to explore the role and responsibility of women and men living in poor urban communities on matters related to family planning (FP). The thesis was guided by the following research question: “How do women and men in poor urban communities describe their role and responsibility on matters related to family planning and how can it be understood using concepts of power, gender norms and roles, and agency?”. To gain insight on the specific phenomenon, the perspectives shared by women and men residing in two poor urban communities in Metro Manila constituted the primary data and were kept in focus throughout the thesis. During January and February of 2018, 16 women and men residing in Bagumbong and Batasan Hills were interviewed. Informed by previous research, a theoretical framework consisting of concepts of power, gender norms and roles, and agency was used as a lens to help explain the respective roles and responsibilities the informants described.

The findings of this thesis demonstrate a gendered division in roles and responsibilities taken on matters concerning FP, which this thesis argues is the result of constructed gender norms and roles that guide women and men on how to be involved in the matter. The theoretical framework helped explain the complexity and the various levels of power that surrounds the phenomenon, which also enabled seeing women and men’s respective roles and responsibilities from various different angles. The following section provides a short summary to the main findings, addresses the links to previous research, and discusses further implications of this study.

The women of this study take the main role and responsibilities in preventing pregnancies. As the majority of the informants use contraceptives developed for women it implicates continuous action from women. This involves seeking information, support and experience from healthcare professionals and friends. It also involves regular visits to the healthcare centers to obtain the contraceptive, which involves avoiding lines and making sure to avail it before they run out of stock. This corresponds to existing research from other income settings addressing the fertility work that falls on women to take responsibility over (Fennell, 2011; Wiggington, 2018). In line with existing research, having the primary role and responsibility in preventing pregnancies is inherited with experienced side effects and time burdens following the stress in planning, obtaining and using the contraceptive. In contrast to the

women, the majority of the men of this study are not involved in matters concerning FP. While a few showed a supportive role for their partners, the majority of the men did not take any responsibility on matters related to contraceptives by referring to their own working hours. The men gave the impression that men in general are unfamiliar in seeking support and information on FP and contraceptives. While some addressed that they found it improper or private to talk about, other found it unnecessary because of their confidence in own knowledge and experience. By applying the theoretical framework, this thesis argues that the gendered division in roles and responsibilities is a result of gender norms and roles that prevail in society and that in turn guides women and men on how to be involved in the matter. As a result of women's actions to prevent pregnancies, and because of men avoiding topics related to FP, they also comply and give their consent to the gender norms and roles guiding them. This in turn means that while they are subordinated to the norms and roles associated to their gender, they also reproduce the norms and roles through their actions. So even though women have the power and control over contraceptives, the choices made to enhance the wellbeing of the women are shaped and constrained to the norms and role that prevails in society.

Despite the focus of previous research relates to women's responsibilities on contraceptive matters in HIC, this thesis demonstrates that similar burdens exist in other income settings. Even though one could argue that women in these areas have other structures that limit their empowerment in different spheres of society, it is important to understand how these responsibilities play out locally. Despite the sample size, this thesis informs the RPRH act on how the division of fertility work is divided among poor urban couples. Not only does it direct attention to the unequal burden women take in preventing pregnancies but it also addresses concern for men's ability to access information and support on matters related to FP and contraceptives. This is of particular importance as these issues does not only harm and makes men vulnerable in the system, but it also creates an increased burden on women as bearer for the RH work. Therefore, in order to make responsible parents through the RPRH act, more emphasis needs to be directed on enabling men and fathers in seeking information and support while directing attention to minimizing the unequal burden on women and mothers.

References

- Abada, T. and Tenkorang, E. Y. (2012). Women's Autonomy And Unintended Pregnancies in The Philippines. *Journal of Biosocial Science* 44: 703-718.
- Allen, A. (1999). *The power of feminist theory: domination, resistance and solidarity*. Boulder: USA.
- Almaden, C. R. and Navarro, K. D. (2015). The social cost of upgrading informal settlements in Butuan City, Philippines. *Journal of Urban Regeneration and Renewal* 9 (3): 295-310.
- Ballesteros, M. (2010). *Linking Poverty and the Environment: Evidence from Slums in Philippine Cities*. Makati City: Philippine Institute for Development Studies. [online] <https://dirp4.pids.gov.ph/ris/dps/pidsdps1033.pdf>, Accessed 2017-12-03
- Bautista, J. (2010). Church and State in the Philippines: Tackling Life Issues in a "Culture of Death". *Journal of Social Issues in Southeast Asia* 25 (1): 29-53.
- Baxter, P. and Jack, S. (2008). Qualitative Case Study Methodology: Study Design and Implementation for Novice Researchers. *The Qualitative Report* 13 (4): 544-559.
- Bertotti, A. M. (2013). Gendered Divisions of Fertility Work: Socioeconomic Predictors of Female Versus Male Sterilization. *Journal of Marriage and Family* 75: 13-25.
- Blanc, A. K. (2001). The Effect of Power in Sexual Relationships on Sexual and Reproductive Health: An Examination of the Evidence. *Studies in Family Planning* 32 (3): 189-213.
- Brillon, C. A. A. (2013). The Role of "Occupy for Reproductive Health" as a Political Tool for Women's Rights and Empowerment. *Asian Journal of Women's Studies* 19 (1): 65-92.
- Brod, H. and Kaufman, M. (1994). *Theorizing Masculinities*. Thousand Oaks: Sage Publications, Inc.
- Bryman, A. (2012). *Social Research Methods*. Oxford: Oxford University Press.
- Butler, J. (1988). Performative acts and Gender Constitution: An essay in Phenomenology and Feminist Theory. *Theatre Journal* 40 (4): 519-531.
- Butler, J. (1999). *Gender Trouble: Tenth Anniversary Edition*. New York: Routledge. E-book.
- Cabalfin, E. (2014). The Politics of Nation in the Urban Form of Informal Settlements in Quezon City, Philippines. In Elleh, N. *Reading the Architecture of the Underprivileged Classes A Perspective on the Protests and Upheavals in Our Cities*. Routledge: New York.
- Cabral, E. I. (2016). The Philippine Health Agenda for 2016 to 2022. *Philippine Journal of Internal Medicine* 54: (2): 1-11.

- Cates, W. Jr. and Maggwa, B. (2014). Family planning since ICPD- how far have we progressed? *Contraception* 90: 14-21.
- Chikiamco, C. and Fabella, R. V. (2011). Property rights reform in the Philippines: the Residential Free Patent Act. In: the Asia Foundation (ed.) *Built on Dreams, Grounded in Reality: Economic Policy Reform in the Philippines*. Makati City: The Asia Foundation.
- Choi, N. (2016). Metro Manila through the gentrification lens: Disparities in urban planning and displacement risks. *Urban Studies* 53 (3): 577-592.
- Collantes C.F. (2018). Reproductive Dilemmas in Metro Manila, Faith, Intimacies and Globalization. In *Gender, Sexualities and Culture in Asia*. Palgrave Macmillan: Singapore. E-book.
- Coltrane, S. (1989). Household labor and the routine production of gender. *Social Problems* 36: 473-490.
- Connell, R. W. (1987). *Gender and Power: Society, the Person and Sexual Politics*. Oxford: Polity Press. E-book.
- Connell, R. W. and Messerschmidt, J. W. (2005). Hegemonic Masculinity Rethinking the Concept. *Gender & Society* 19 (6): 829-859.
- Connell, R. W. (2012). Gender, health and theory: Conceptualizing the issue, in local and world perspective. *Social Science & Medicine* 74 (11): 1675-1683.
- Cope, D. G. (2014). Methods and Meanings: Credibility and Trustworthiness of Qualitative Research. *Oncology Nursing Forum* 41 (1): 89-91.
- Creswell, J. W. (2012). *Qualitative Inquiry & Research Design, Choosing Among Five Approaches*. Thousand Oaks: Sage.
- Crook, N. (1996). Population and Poverty in Classical Theory, Testing a Structural Model for India. *Population Studies* 50: 173-185.
- Cruz, J. E. (2010). *Estimating Informal Settlers in the Philippines*. 11th National Convention on Statistics (NCS). Makati City.
- David, C. C., Atun, J. M. L. and La Vina, A. G. M. (2012). Framing in Legislation: The Case of Population Policy in the Philippines. *Population Res Policy Rev* 31: 297-319.
- David, C. C. and Atun, J. M. L. (2014). Factors Affecting Fertility Desires in the Philippines. *Social Science Diliman* 10 (2): 100-119.
- Davis. E. (2017). What is it to Share Contraceptive Responsibility? *Topoi* 36: 489-499.
- Department of Health (DOH), Responsible Parenthood and Reproductive Health National Implementation Team and Regional Implementation Teams. (2014). *The First Annual Consolidated Report on the Implementation of the Responsible Parenthood and Reproductive Health Act of 2012 (R. A. No. 10354)*. [online]

<https://drive.google.com/file/d/0B7yD0Z1BkW0fYnFUdDVtRkJhVUE/view> Accessed on: 21.03.2018.

Department of Health (DOH) and the Commission on Population (POPCOM). (2017). *3rd Annual Report on the Implementation of the Responsible Parenthood and Reproductive Health Act of 2012*. Manila: Philippines.

Department of Social Welfare and Development (DSWD). (n.d.). *Pantawid Pamilyang Pilipino Program Frequently Asked Questions*. [online] <http://pantawid.dswd.gov.ph/images/stories/pantawidfaq.pdf> Accessed on: 22.03.2018.

Dumez, H. (2015). What is a Case, and What Is a Case Study? *Bulletin de Methodologie Sociologique* 127: 43-57.

England, K. (1994). Getting Personal: Reflexivity, Positionality and Feminist Research. *The Professional Geographer*. 46 (1): 80-89.

Eviota, E. U. 1992. *The political economy of gender: women and the sexual division of labour in the Philippines*. London: Zed Books.

Fennell, J. L. (2011). Men Bring Condoms, Women Take Pills. *Gender & Society* 25 (4): 496-521.

Fernandez, L. (2012). Design and implementation features of the national household targeting system in the Philippines. *Philippine social protection: no. 5*. Washington DC: World Bank. [online] <http://documents.worldbank.org/curated/en/687351468093838577/Design-and-implementation-features-of-the-national-household-targeting-system-in-the-Philippines> Accessed on: 04.29.2018.

Flyvbjerg, B. (2006). Five misunderstandings about case-study research. *Qualitative inquiry*. 12 (2): 219-245.

Foucault, M. (2000). *Power: The essential works of Foucault, 1954-1984, Volume III*. New York: Penguin.

Funder, M. (2005). Bias, intimacy and power in qualitative fieldwork strategies. *The Journal of Transdisciplinary Environmental Studies* 4 (1): 1-9.

Fyall, R. and Gazley, B. (2015). Applying Social Role Theory to Gender and Volunteering in Professional Associations. *Voluntas* 26: 288-314.

Gardiner, J. K. (2005). Men, Masculinities, and Feminist Theory. In Michael Kimmel, Jeff Hearn and Robert W. Connell *Handbook of Studies on Men & Masculinities*. Thousand Oaks: Sage.

Germain, A., Sen, G., Garcia-Moreno, C. and Shankar, M. (2015). Advancing sexual and reproductive health and rights in low- and middle-income countries: Implications for the post-2015 global development agenda. *Global Public Health* 10 (2): 137-148.

- Grady, M. P. (1998). *Qualitative and Action Research: A practitioner Handbook*. Bloomington: Phi Delta Kappa Educational Foundation.
- Greer, G. (2009). To have or not to have: The critical importance of reproductive rights to the paradox of population policies in the 21st century. *International Journal of Gynecology and Obstetrics* 106: 148-150.
- Golding, C. and Katz, L. F. (2002). The Power of the Pill: Oral Contraceptives and Women's Career and Marriage Decisions. *Journal of Political Economy* 110 (4): 730- 770.
- Guttmacher Institute and Likhaan. (2010). *Facts on Barriers to Contraceptive Use In the Philippines*. Guttmacher Institute. [online] <https://www.guttmacher.org/fact-sheet/facts-barriers-contraceptive-use-philippines> Accessed on: 18.01.2018.
- Hadi, M. (2017). Historical development of the global political agenda around sexual and reproductive health and rights: A literature review. *Sexual & Reproductive Healthcare* 12: 64-69.
- Hammet, D., Twyman, C. and Graham, M. (2014). *Research and Fieldwork in Development*. Routledge: Oxford.
- Harding, S. G. (1987). *Feminism and Methodology: Social Science Issues*. Bloomington: Indiana University Press. E-book.
- Hartmann, B. (1995). *Reproductive Rights and Wrongs The Global Politics of Population Control*. Revised edition. South End Press.
- Hasan, K., Aggleton, P. and Persson, A. (2015). Rethinking Gender, Men and Masculinity: Representations of Men in the south Asian Reproductive and Sexual Health Literatures. *International journal of Men's Health* 14 (2): 146-162.
- Hirschmann, N. (2003). *The Subject of Liberty: Toward a Feminist Theory of Freedom*. Princeton; Oxford: Princeton University Press.
- Hubacher, D. and Trussel, J. (2015). A definition of modern contraceptive methods. *Contraception* 92: 420-421.
- Jacobstein, R., Curtis, C., Spieler, J. and Radloff, S. (2013). Meeting the need for modern contraception: Effective solutions to a pressing global challenge. *International Journal of Gynecology and Obstetrics* 121: 9-15.
- Kabeer, N. (2000). From Concepts to Practice Gender aware Planning through the Institutional Framework. In Kabeer, N. and Subrahmanian, R. *Institutions, relations and outcomes: a framework and case studies for gender-aware planning*. London: Zed.
- Kabeer, N. (2005). Gender equality and women's empowerment: a critical analysis of the third Millennium Development Goal. *Gender and Development* 13 (1): 13-24.
- Kabeer, N. (2012). Empowerment, Citizenship and Gender Justice: A Contribution to Locally Grounded Theories of Change in Women's Lives. *Ethics and Social Welfare* 6 (3): 216- 232.

- Kennedy, E., Gray, N., Azzopardi, P. and Creati, M. (2011). Adolescent fertility and family planning in East Asia and the Pacific: a review of DHS reports. *Reproductive Health* 8 (11): 1-12.
- Kimport, K. (2018). Talking about male body-based contraceptives: The counseling visit and the feminization of contraception. *Social Science & Medicine* 201: 44-50.
- Lai, S., Tey, N. P. and Ng, S. T. (2017). Socio-economic Status and Fertility: A study of Selected ASEAN Countries. *Malaysian Journal of Economic Studies* 54 (1): 119-140.
- Lane, S. D. (1994). From Population Control To Reproductive Health: An Emerging Policy Agenda. *Social Science & Medicine* 39 (9): 1303-1314.
- Lara, W., Castro, J. and Yap, D. (2017). *Spatio-Temporal Analysis of Quezon City Informal Settlements: Towards a QC Informal settlements Growth Model*. Presented at the "2017 World Bank Conference on Land and Poverty". Washington DC: the World Bank.
- Lim Tan, M. (2004). Fetal Discourses and the Politics of the Womb. *Reproductive Health Matters* 12 (24): 157-166.
- Lopez- del Burgo, C. and de Irala, J. (2016). Modern contraceptive methods: a new misleading definition. *Contraception* 2016 (93): 565-566.
- Luke, S. (2005). *Power: a radical view*. London: Macmillan.
- Lusher, D. and Robins, G. (2009). Hegemonic and Other Masculinities in Local Social Contexts. *Men and Masculinities* 11 (4): 387-423.
- Marquez, M. P. N., Kabamalan, M. and Laguna, E. (2017). *Ten Years of Traditional Contraceptive Method Use in the Philippines: Continuity and Change*. DHS Working Papers No. 130. Rockville, Maryland, USA: ICF.
- May, T. (2011). *Social Research: Issues, Methods and Research*. London: Sage.
- Montiel, C. J., Umel, A. and de Leon, M. (2016). Discursive Construction of Political Categories and Moral Fields: God Versus Rights and Access in a Reproductive Health Legislative Debate. *Political Psychology* 37 (6): 853-866.
- Morin, V. M., Ahmad, M. M. and Warnitchai, P. (2016). Vulnerability to typhoon hazards in the coastal informal settlements of Metro Manila, the Philippines. *Disasters* 40 (4): 693-719.
- Moses, J. W. and Knutsen, T. L. (2012). *Ways of Knowing, Competing Methodologies in Social and Political Research*. Houndmills: Palgrave Macmillan.
- National Economic and Development Institute (NEDA) (2011). *Philippine Development Plan 2011-2016*. NEDA, Pasig City, Philippines.

Parmanand, S.(2014). Mapping the Path of Philippine Reproductive Rights Legislation: Signs of Progress Amidst Obstacles. *Journal of the Global South* 2 (1): 61-80.

Paul, M., Essén, B., Sariola, S., Iyengar, S., Soni, S. and Klingberg Allvin, M. (2017). Negotiating Collective and Individual Agency: A Qualitative Study of Young Women's Reproductive Health in Rural India. *Qualitative Health Research* 27 (3): 311-324.

Philippine Statistics Authority (PSA). (2016). Population of the National Capital Region (Based on the 2015 Census of Population). [online]
<https://psa.gov.ph/content/population-national-capital-region-based-2015-census-population-0> Accessed on: 05.02.2018.

Philippine Statistics Authority (PSA) and ICF. (2018). *Philippines National Demographic and Health Survey 2017: Key Indicators*. Quezon City, Philippines, and Rockville, Maryland, USA: PSA and ICF.

Pillai, V. K. and Gupta, R. (2011). Reproductive rights approach to reproductive health in developing countries. *Global Health Action* 4 (1): 8423.

Pingol, A 2001, *Remaking Masculinities : Identity, Power, And Gender Dynamics In Families With Migrant Wives And Househusbands*, n.p. UP Center for Women's Studies Quezon City: Ford Foundation.

Raffin, A. and Corneliio, J. S. (2009). The Catholic Church and education as sources of institutional panic in the Philippines. *Asian Journal of Social Science* 37 (5): 778-798.

Ragin, C. C. and Amoroso, L. M (2011). *Constructing Social Research, The Unity and Diversity of Method*. Pine Forge Press: Thousand Oaks.

Rao, A. and Kellener, D. (2002). *Unravelling institutionalised gender inequality*. Occasional Paper No.8. Toronto: AWID.

Reyes, C., Tabuga, A., Asis, R. and Blesila Datu, M. (2012). Poverty and Agriculture in the Philippines: Trends in Income Poverty and Distribution. Makati City: Philippine Institute for Development Studies.

RPRH. (2012). *Responsible Parenthood and Reproductive Health Act of 2012*. No. 10354. Republic of the Philippines. [online]
http://pcw.gov.ph/sites/default/files/documents/laws/republic_act_10354.pdf Accessed on: 10.10.2017.

Ruiz Austria, C. S. (2004). The Church, the State and Women's Bodies in the Context of Religious Fundamentalism in the Philippines. *Reproductive Health Matters* 12 (24): 96-103.

Saldana, J. (2009). *The Coding Manual for Qualitative Researchers*. London: Sage.

Saunders, B., Sim, J., Kingstone, T., Baker, S., Waterfield, J., Bartlam, B., Burroughs, H. and Jinks, C. (2017). Saturation in qualitative research: exploring its conceptualization and operationalization. *Quality & Quantity*: 1-15.

- Scheyvens, R. (2014). *Development Fieldwork, A Practical Guide*. 2nd ed. London: Sage.
- Shenton, A. K. (2004). Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information* 22: 63-75.
- Smith, E. S. (2014). Reproductive Justice Begins With Contraceptive Access In The Philippines. *Pacific Rim Law & Policy Journal Association* 23 (1): 203-249.
- Starbird, E., Norton, M. and Marcus, R. (2016). Investing in Family Planning: Key to Achieving the Sustainable Development Goals. *Global Health Science Practice* 4 (2): 191-210.
- Sultana, F. (2007). Reflexivity, positionality and participatory ethics: Negotiating fieldwork dilemmas in international research. *ACME: An International E-Journal for Critical Geographies* 6(3): 374-385.
- Tallis, V. (2012). *Feminisms, HIV and AIDS, Subverting Power, Reducing Vulnerability*. London: Palgrave Macmillan. E-book.
- Tanyag, M. (2015). Unravelling the intersections of power: The case of sexual and reproductive freedom in the Philippines. *Women's Studies International Forum* 53: 63-72.
- Tanyag, M. (2017). Invisible labor, invisible bodies: how the global political economy affects reproductive freedom in the Philippines. *International Feminist Journal of Politics* 19 (1): 39-54.
- Townsend, J. W., Sitruk-Ware, R., Williams, K., Askew, I. and Brill, K. (2011). New strategies for providing hormonal contraception in developing countries. *Contraception* 83: 405-409.
- Vistro, T. (2014). Poverty, Food Insecurity, And Sexual And Reproductive Health And Rights In The Post-2015 Agenda: Considerations from the Philippines. *Arrow for change* 20 (1): 7-9.
- Wernet, C. A. (2016). The Intersectionality of gender, Rights, and Privilege: A Comparative Analysis of 127 Countries. *Comparative Sociology* 15: 252-271.
- Wiggington, B., Harris, M. L., Loxton, D. and Lucke, J. (2018). Who takes responsibility for contraception, according to young Australian women? *Sexual & Reproductive Healthcare* 15: 2-9.
- WHO. (2018). Family planning/Contraception Fact sheet. February 2018. [online] <http://www.who.int/mediacentre/factsheets/fs351/en/> Accessed on: 21.03.2018.
- Yin, R. (2003). Qualitative quality: Eight "big-tent" criteria for excellent qualitative research. *Qualitative inquiry* 16 (10): 837-851.
- Yin, R. (2009). *Case Study Research: Design and Methods*. 4th ed. Sage: CA. E-book.

Yin, R. (2014). *Case Study Research: design and methods*. 5ed. London: SAGE.

United Nations (UN), Department of Economic and Social Affairs, Population Division (2015). *Trends in Contraceptive Use Worldwide 2012* (ST/ESA/SER.A/349). [online] <http://www.un.org/en/development/desa/population/publications/pdf/family/trendsContraceptiveUse2015Report.pdf> Accessed on: 25.04.2018.

UNFPA. (2012). *Impacts of Population Dynamics, Reproductive Health and Gender on Poverty*. [online] <https://www.unfpa.org/sites/default/files/pub-pdf/UNFPA-Impacts%20on%20Poverty-1.pdf> Accessed on 25.04.2018.

UNFPA. (2014). *Programme of Action of the International Conference on Population Development*. [online] http://www.unfpa.org/sites/default/files/pub-pdf/programme_of_action_Web%20ENGLISH.pdf Accessed on: 14.09.2017.

UNFPA. (2016). *Universal Access to Reproductive Health*. Report for United Nations Population Fund. [online] http://www.unfpa.org/sites/default/files/pub-pdf/UNFPA_Reproductive_Paper_20160120_online.pdf Accessed on: 14.09.2017.

UNFPA. (2017). *Worlds Apart Reproductive health and rights in an age of inequality*. [online] https://www.unfpa.org/sites/default/files/pub-pdf/UNFPA_PUB_2017_EN_SWOP.pdf Accessed on: 21.03.2018.

UNFPA. (2017b). 20 July. Family Planning Overview. [online] <https://www.unfpa.org/family-planning> Accessed on: 21.03.2018.

Appendices

Appendix A

Interview guide

Women and men

Social characteristics

- Age
- Marital status
- Number of children
- Where do you come from?
- Employment
- Contraceptive use (**modern or natural**)

Questions

1. How can people here in X access Family planning services and modern contraceptives?
 - What choices are there available?
 - Is it easy/difficult to access?
2. What do you think about contraceptives (modern/natural)?
3. What kinds of contraceptives are you using/have used before (modern/natural)?
 - Why did you decide to use that method? (Other options?)
4. Do you and your partner have the same opinion on contraceptives?
 - Describe.
5. Do you think that men and women have the same opinion on contraceptives?
 - Why/How different/same?
 - What about responsibilities, who take responsibility for contraceptives?
 - How are men/women involved in contraceptive (obtaining, control)?
6. Have you ever experienced a need for contraceptives but without ability to access/or use it?
 - Why/how did that happen? What did you do?
7. Who do you talk about contraceptives or family planning services with?
8. Is contraceptive anything that you would talk about with friends, family, neighbors etc.? (Why/why not?)
 - Would you share (friends, family, neighbors) what method you are using? (Why/why not?)
 - Would you ask someone for advice on contraceptives? (Who? Why?)
 - How would you respond if someone were asking for your advice? (Who would that be?)
9. What do you think the general opinion is towards contraceptives?
 - Why?
 - Is it different between different people? How? Women/women, men/men, older/younger? (Why? What's the reason?)

10. If you heard that someone in your community/that you know was using modern/natural contraceptives, how would you think about it and what would you do? (e.g. family member, friends, neighbor)
11. If the majority of people you know (in your community) would not support your use of contraceptive, what would you do?

Appendix B

List of modern and traditional contraceptive methods used by the informants of this thesis. The information of the different contraceptive methods have been collected from WHO's website. The reference can be found in the reference list.

The Pill

The combined oral contraceptives, or pills, are a hormonal contraceptive that women take to prevent ovulation. If the method is used correctly and consistently, it prevents pregnancies with >99%.

Injectable

The injectable is a hormonal, long-acting contraceptive method that is injected into the woman's body, either through the muscle or under the skin. Because it thickens the cervical mucus, the injectable helps to block the sperm and egg from meeting and thus hinders ovulation. Women are injected with the contraceptive by a health provider, which then lasts for approximately three months. Among those who use it regularly, the injectable is >97 percent effective against pregnancies.

Implants

The implant is a longer acting modern contraceptive method, which can be used for three to five years. The contraceptive is a rod that is placed inside the upper arm of the woman by a healthcare professional. The implant contains hormones, which blocks the sperm and egg from meeting and thus hinder ovulation. The method is very effective in preventing pregnancies (>99 percent).

Intrauterine Contraceptive Device

The intrauterine contraceptive Device (IUD) is a hormonal longer acting modern contraceptive. The IUD is a plastic device that contains copper wire that is inserted into the uterus by a healthcare professional. The IUD damages the sperm and in such way prevents it from meeting the egg. It is very effective in preventing pregnancies with >99 percent.

Male Condoms

The male condom, henceforth will be referred to as condom, is a sheaths that is put over a man's erect penis, which creates a barrier that prevents the sperm to meet the egg. If used properly, the condom has a >98 percent effectiveness to prevent pregnancies while it also protects against STIs.

Female sterilization and Male sterilization

Female sterilization is a permanent contraceptive that involves a medical procedure that prevents the sperm to reach the eggs. It has a >99 percent effectiveness.

Male sterilization is also a permanent contraceptive that entails a medical procedure that keeps the sperm from the semen. The method is >99 percent effective in preventing pregnancies.

Withdrawal

This method involves the man who withdraws the penis from the vagina before ejaculation, which keeps the semen away from the woman's genitals. It is 96 percent effective against

pregnancies if used correctly and consistently. However, because the difficulty in timing and determining when to withdraw, the method is not considered very effective.

Calendar method

The calendar method involves monitoring of the menstrual cycle to calculate which days the woman is most fertile. To prevent a pregnancy, the couple avoids having unprotected vaginal sex during the 1st and the last days within the period of fertile days by either abstaining from sex or using a condom. Therefore, the method involves both partners and relies to a large extent on negotiation to prevent pregnancies. The calendar method does not require regular visits to a healthcare center as long as the couple knows how the method works. The method has 91 percent effectiveness against pregnancy if used correctly and consistently.

Appendix C

Informed consent

First of all, thank you very much for being here today. This document serves to inform you about the research I am doing and how I wish to involve you. My name is Katarina Lindgren Cortés and I am a Master's student studying International Development and Management in Sweden. I am here in the Philippines to interview people regarding contraceptives.

The purpose of this study is to understand what view you and the people of your community have on family planning services and contraceptives. For me to be able to understand your views, I would like to interview you. I will specifically ask questions on your opinion of contraceptives as well as how people around you talk about contraceptives.

If you agree to the interview, it will be audio recorded and will last approximately 40 to 60 minutes. What you share during the interview might be quoted and used in the thesis but without using your name. Your name, address and everything you share during the interview will be properly stored to keep you anonymous. The information you share will only be used for this thesis and will not be shared to anyone outside this study project. To participate in this study is completely voluntary and if you decide to be interviewed, you always have the choice not to answer specific questions or end the interview at anytime.

By signing this document I consent to participate in this study and that I understand the above.

Participant:

Name, date

Thank you very much for agreeing to take part in this study.

If you have any questions about the study at any stage, please do not hesitate to contact me.

Contact details

Katarina Lindgren Cortés

Email: ka4105co-s@student.lu.se

Tagalog version

KASULATAN NG MAY KAALAMAN PAHINTULOT

Maraming salamat sa pagdalo. Kayo po ay inaanyayahan kong lumahok ng may kusang loob, sa pag-aaral o *research* na ito. Ang dokumentong ito ay naglalayong maipaalam sa inyo ang mga detalye ukol sa pag-aaral na ito. Ako po si **Katarina Lindgren Cortes**, isang mag-aaral o estudyante sa Sweden. Bilang bahagi ng aking pag-aaral para sa kursong *Master sa International Development and Management*, andito po ako upang makipagpanayam ukol sa *contraceptives*.

Layon ng pag-aaral na ito na intindihin o unawain ang pananaw nyo at ng inyong komunidad ukol sa mga **family planning services o mga serbisyo para sa pagpapalano ng pamilya**. Upang maisalarawan at maunawaan ko ang inyong pananaw, hihingin ko ang inyong pahintulot para sa **isang panayam o interbyu**. Bilang bahagi ng panayam na ito, magtatanong po ako ng mga partikular na katanungan upang hingin ang inyong opinyon, at ang opinyon ng mga tao sa inyong komunidad sa nasabing pokus ng pag-aaral na ito.

Ang interbyu o panayam na ito ay magtatagal ng 40 minuto hanggang 1 oras. Ito po ay irerekord gamit ang isang *audio recorder*. Bagamat maaring mailimbag o maisulat ang inyong ibabahaging mga kasagutan, ang inyong mga pangalan, kasama ang iba pang personal na impormasyon, ay hindi ibubunyag. **Bilang mananaliksik sisiguraduhin kong ang lahat ng mga makakalap na kasagutan, lalo na ang personal na impormasyon, ay itatago at pananatilihin pribado**. Ang paglahok sa pag-aaral na ito ay boluntaryo o kusang loob, at hindi sapilitan. Hindi ninyo kinakailangang sagutin ang lahat ng katanungan. Maari din ninyong kanselahin o bawiin ang inyong partisipasyon sa anumang oras at nang walang anumang dahilan.

Maraming salamat sa pagbibigay-oras. Para sa mga katanungan kaugnay sa pag-aaral na ito, pakitingnan ang mga sumusunod na detalye:

Sa pagpirma sa kasulatan ng pahintulot na ito,

Katarina Lindgren Cortés

Email: ka4105co-s@student.lu.se