

PN-AAW-444
48906

ORAL CONTRACEPTIVE MARKETING IN BANGLADESH
VOLUME I. BACKGROUND, TABLES AND QUESTIONNAIRES

FINAL REPORT

Prepared for: Bangladesh Family Planning Social Marketing
Project and Population Services International.

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Supported by: Office of Population and Health, USAID Mission
to Bangladesh

Honolulu, December, 1984

ACKNOWLEDGEMENTS

The study is a joint effort of the Social Marketing Project management, USAID office of Population and Health/Bangladesh, Population Services International, Mitra and Associates, and John Davies, Family Planning Consultant. The authors wish to thank Mr. S. Anwar Ali, Mr. W.P.Schellstede and the management of the project for their continuing helpful participation. We are grateful also for the financial support of USAID and particularly wish to thank Mr. John Thomas and Dr. Carol Carpenter of the USAID Mission to Bangladesh for their helpful comments and technical suggestions during the planning stage. We hope that the results of the study will be a suitable reward for the efforts of all the participants.

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PURPOSE AND BENEFITS

This market research is designed to assist the Social Marketing Project (SMP) managers to improve the marketing and use of their oral contraceptives. Specifically, the information resulting from the study can be used to modify oral contraceptive marketing strategy.

The immediate benefit of the study is the practical information provided to management. Intermediate-term benefits should include increased sales, prevalence, effectiveness and duration of use of SMP oral contraceptives. Longer-term benefits should include lower fertility and improved health for users.

THE MARKETING PROBLEM

The SMP began marketing one brand of oral contraceptives ("Maya") in 1976 but after three years sales leveled unacceptably and it appeared that the marketing strategy was inappropriate. It was decided that the brand name was not strong enough, the price not high enough, and the providers not prestigious enough to give the product the necessary image required to attract more users. Importantly, drop-out rates were high and these were partly attributed to the influence of health practitioners who were not retailing Maya and who conveniently blamed oral contraceptive use for the sometimes ill-defined complaints of local women.

A new strategy was implemented in 1980 which included an additional product ("Ovacon") and an additional type of provider, the health practitioners. The distribution strategy then emphasized three types of providers, namely graduate doctors, rural health practitioners and pharmacy shops, while de-emphasizing other types of shops used previously. The new strategy has worked well. Sales of Maya and Ovacon have increased steadily.

Although popularity of SMP pills has increased, management does not have adequate information about the providers, purchasers and users or about the flow of pill-taking instructions from the providers to the purchasers and users. Furthermore, management does not have adequate information on use patterns. These kinds of information are needed to help plan marketing strategies and to evaluate effectiveness of oral contraception. To provide management with this information it was decided to survey samples of SMP providers, purchasers and users of oral contraceptives (OCs).

OBJECTIVES OF THE RESEARCH

1. To identify and describe the characteristics of SMP OC providers, customers and customers' spouses.
2. To identify and describe the role of the users' husbands in purchasing OCs and communicating knowledge of OCs to the users.
3. To identify and describe instructions about OC use that flow from SMP providers (graduate Doctors, Health Practitioners and Pharmacists).
4. To identify and describe OC knowledge among users and husbands.
5. To identify and describe patterns of OC use among SMP customers.
6. To identify and describe perceived problems of OC use.
7. To identify and describe reasons for dissatisfaction about and discontinuation of OCs among SMP customers.
8. To identify and describe users' perceptions of relationships between breastfeeding, amenorrhea and OC use.
9. To compare attributes of current users and past users.
10. To synthesize the above information into practical recommendations.

METHODOLOGY

Sample design:

The hormonal contraceptive study was designed to be conducted by covering some purposively selected areas rather than the country as a whole. The national coverage of the study was considered neither necessary nor feasible for the following reasons:

1. The study was intended not for deriving any national estimates but for providing SMP with information for developing their marketing strategies for hormonal contraceptives.
2. Obtaining national coverage was found to be too costly.
3. Gains that would have accrued from the national coverage would probably not be commensurate with the additional cost.
4. The time needed to complete the study with national coverage would have been exceptionally long, making some of the results obsolete.
5. Market researches are often based upon area data rather than on national data sets.

TABLE A -- Sampled providers by category and stratum

DISTRICTS/ UPAZILAS	GRAD.	HEALTH	PHARMACY	DOCTOR WITH PHARMACY		ALL
	DOCTOR	PRACTITIONER		DOCTOR	HEALTH PRAC.	
<u>Rural Stratum:</u>						
<u>RAJSHAHI</u>						
Chargat	2	3	3	-	3	11
Badalgachi	4	2	3	-	-	9
<u>BOGRA</u>						
Dhupchachia	3	3	4	-	-	10
Panchbibi	3	-	4	1	5	13
<u>RANGPUR</u>						
Hatibandha	5	-	-	-	3	8
Polashbari	3	10	4	-	-	17
Sub-total	20	18	18	1	11	68
<u>Urban Stratum:</u>						
<u>RAJSHAHI</u>						
Rajshahi town	3	-	4	6	3	16
<u>BOGRA</u>						
Joypurhat	3	-	3	2	3	11
<u>RANGPUR</u>						
Lalmonirhat	4	6	-	1	2	13
Nilphamari	2	6	4	2	1	15
Sub-total:	12	12	11	11	9	55
Total:	32	30	29	12	20	123

TABLE B -- Identified, located and interviewed couples
by stratum and Upazila

DISTRICTS/ UPAZILAS	IDENTIFIED	LOCATEL	INTERVIEWED
<u>Rural Stratum:</u>			
<u>RAJSHAHI</u>			
Chargat	45	44	32
Badalgachi	27	27	27
<u>BOGRA</u>			
Dhupchachia	30	29	21
Panchbibi	39	39	37
<u>RANGPUR</u>			
Hatibandha	24	24	24
Polashbari	84	81	59
Sub-total	249	244	200
<u>Urban Stratum:</u>			
<u>RAJSHAHI</u>			
Rajshahi (Sadar)	31	29	24
Natore	31	30	23
<u>BOGRA</u>			
Jaypurhat	33	33	33
<u>RANGPUR</u>			
Lalmonhirhat	56	54	38
Nilphamari	52	50	36
Syedpur	15	15	11
Sub-total:	218	211	165
Total:	467	455	365

The following three districts (old classification) were purposively selected to constitute the study population: Rajshahi, Bogra, and Rangpur. The reason for selecting those districts was the belief of the SMP management that marketing situations in those districts would, on average, be close to the national level.

The study needed data from three different but interdependent samples; 1. the sample of providers of SMP brands of oral contraceptives (the provider sample) 2. their clients--users and husbands of users (the user/husband sample), and 3. past users of any brands of oral contraceptives (the past user sample).

Of the three samples, the provider sample was first drawn, while the other two samples emanated from that sample. Thus any descriptions of the sample selection procedures must begin with the provider sample.

The provider sample was drawn as follows:

First, the upazilas in the three districts were grouped into two strata - urban and rural. Upazilas under the district and subdivisional townships were put into the urban stratum, and those outside the townships in the rural stratum. As such, of the 45 upazilas in the three districts, 13 were grouped under the urban stratum, including 4 from Rajshahi, 3 from Bogra and 6 from Rangpur; and 32 under the rural stratum, including 9 from Rajshahi, 9 from Bogra and 14 from Rangpur.

Second, ten upazilas were randomly selected as the first stage sample, by drawing 4 upazilas from the urban stratum, and 6 upazilas from the rural stratum. The provider sample was selected at the second stage by taking, on average, three providers for each category from each selected upazila. The selection of providers was done by using the list of SMP providers supplied by SMP marketing management. For some upazilas the number of providers selected for a particular category was less than three, while being higher than three in some others. This was either due to total absence of the category having less than 3 providers in that upazila. Because of this, more than 3 providers for some categories from some upazilas had to be selected in order to have a total sample of 124 providers with 32 graduate doctors, 30 Health Practitioners, 30 pharmacists and 32 pharmacies with graduate doctors or Health Practitioners.

Third, after selecting the provider sample, attempts were made to interview each of the providers included in the sample and obtain from them the list of their users for selection of the user/husband sample. Table 1 shows the distribution of selected and located providers by category and stratum. Of the selected 124 providers, 118 (95.1%) were located in the field. But only 99 selected providers (85%) could be successfully interviewed. In most cases, the reason for unsuccessful interview was that the provider did not report himself as dealing with SMP oral contraceptives. As such, 24 additional providers had to be interviewed outside the sample to obtain all 123 provider interviews. Thus, the obtained provider sample was made up of 32 graduate doctors, 30 Health Practitioners, 29 pharmacists and 32 pharmacies with Health Practitioners/graduate doctors. The

sampling design is summarized in Table A.

The user-couple sample was drawn by selecting, on average, 3 to 4 user couples for each interviewed provider. Table B shows the distribution of identified, located and interviewed user couples by stratum. Out of 467 user-couples selected (rural 249, urban 218), 455 were located in the field. Thus, the proportion of the not located couples was only 2.6 percent, rural 2.0 percent and urban 3.3 percent. As shown in Table B, the number of successfully interviewed couples was 365, or 80.2 percent of the located couples. Thus, the rate of non-response among located user couples stood at 19.8 percent, rural 18.0 percent, and urban 21.8 percent. The absence of one partner was the reason for non-response in most cases.

The discontinued user sample was drawn by selecting 100 discontinued users from among the names of discontinued users, collected from the interviewed wives and husbands.

Data from the user and past user samples were collected by simultaneously but separately interviewing both partners of the couple. Thus, a selected couple was not interviewed if both partners could not be administered the questionnaire simultaneously.

Questionnaires:

Two questionnaires were used in the study; one for interviewing providers and the other for interviewing users and their husbands. The formats of the questionnaires are outlined in Table C. The questionnaire for the provider had 8 sections, and that for the users and husbands had 7 sections. Each section was devoted to collecting specific types of information. Importantly, the first five sections of the two questionnaires were parallel, that is, the questionnaires were made to be of similar nature for comparison during the analysis.

The questionnaires were pretested twice. The first pretesting was done in the subdivision of Manikgonj and the second pretesting in the district of Jamalpur. The first pretesting was conducted over five days, employing the field personnel of Mitra and Associates who had worked in the 1983 Contraceptive Prevalence Survey. The first pretesting was completed with 10 interviews of providers and 16 interviews of couples (users and husbands).

The first pretest provided rewarding experiences about the complexities of the questionnaires and the problems that were likely to be associated with the actual field work such as approaching and interviewing busy Doctors, Health Practitioners and Pharmacists, obtaining names of clients or customers from the providers, and locating the users and their husbands.

The second pretest used an interviewing team comprised of two supervisors (one male and one female), ten interviewers (five male and five female) and one cook/logistical assistant.

TABLE C -- Questionnaire section headings

SECTION	PROVIDER	USERS/HUSBANDS
1	Background characteristics	Background characteristics
2	Retail patterns	Buying patterns
3	Providers relationship with couples	Instructions received
4	Users' problems	Users' practices and problems
5	Attitudes about hormonal contraceptives	Attitudes about hormonal contraceptives
6	Relationship with M.B.B.S. (graduate doctors) (Health Practitioners only)	Child rearing history (for women only)
7	Relationship with rural health practitioners (for graduate doctors only)	Past users
8	Relationship with doctors (for pharmacists only)	

During the second pretest, ten interviews were taken for providers and 36 couples (users and husbands) over a period of one week. This pretest proved the efficacy of the questionnaires and provided experience needed for planning the sampling procedures for the actual data collection work. After the second pretest, the questionnaires were finalised.

Translation of the Questionnaires:

The questionnaires were translated into Bengali by the professional staff of Mitra and Associates. Three persons were employed for the task. First, the provider questionnaire was translated; then the user/husband questionnaire was done, keeping language consistent with the provider questionnaire.

The translated questionnaires were translated back into English in order to examine if there were any discrepancies between the Bengali and the original English versions of the questionnaires. The back-translation was done by employing an expert translator from outside Mitra and Associates. The reason for using an outside translator was to provide assurance that questionnaires were translated without distorting the meaning and intent of any question. The Bengali translation and back-translation were completed before the second pretest.

Recruitment and Training of Personnel:

The study was conducted by employing personnel from among those who worked in the 1983 Contraceptive Prevalence Survey. There were, in all, 50 persons specifically recruited for the study.

- 2 Project Officers
- 2 Quality Control Officers (1 male and 1 female)
- 4 Supervisors (2 male and 2 female)
- 10 Enumerators-cum-interviewers (all male)
- 20 Interviewers (10 male and 10 female)
- 3 Editors/edit verifiers
- 6 Transcribers/coders/coding verifiers
- 2 Cooks/logistical assistants
- 1 MLSS (office peon)

The Project Officers were the regular professional employees of Mitra and Associates. The other professional staff of Mitra and Associates were also engaged at various stages of the study.

Training of study personnel was given in three phases. First phase training was arranged for interviewers employed to conduct the first pretest. This training was held for two days, confining it to classroom lectures about techniques of filling in the questionnaires. Since each of the interviewers was taken from among field personnel who worked in the 1983 CPS, it was believed that the two-day training would be sufficient to give them the skills required to administer the provider and user questionnaires; but subsequently,

it was realized that the interviewers needed more training to do the job efficiently because of the complexity of the questionnaires.

The second phase training was organized for the field personnel assigned to do the second pretest. Among those personnel were include some new interviewers in addition to those who did the first pretest. The second phase training required 10 days and covered topics such as techniques of selecting respondents, techniques of interviewing, and questionnaire instructions. Out of 10 days, the first seven days were devoted to classroom training, while the remaining days were spent on field practice, and discussions on problems encountered during the field practice.

The third phase training was arranged to prepare the quality control officers, supervisors, and interviewers for the actual field work. This phase required 4 weeks. Topics covered in the third phase training included the purpose of the study, its importance, the role of field personnel, the sample design, procedures of selecting respondents, detailed discussions about the intent of each question asked in the questionnaires, techniques of administering the questionnaires, techniques of spot checking, reinterviewng, and methods of quality control checks. The first two weeks were devoted to classroom training, the third week to field practice, and the fourth and final week to discussions of solutions to field problems.

Field Work:

Field work for the study was carried out during May 6, 1984 to June 17, 1984 with two groups of workers. One group was made up of enumerators and the other group of interviewers. The enumerator group was responsible for interviewing the providers, and collecting from them the names of their OC users in order to provide the frame for selection of the user sample. The enumerator group was divided into two teams, with each team comprising 5 enumerators and one supervisor. The role of the supervisor in each team was to ensure quality of the work done by an enumerator, to help solve problems, if any, faced by the enumerator, to select the user sample from the lists of users prepared by the enumerator, and to furnish the names of selected user-couples to the interviewing group.

The interviewing group was organized into four teams, with each team made up of two supervisors (one male and one female), two male interviewers, two female interviewers and one cook/logistical assistant. The original plan was to conduct the interviewing work by organizing the interviewing group into two teams, with each team comprising two supervisors (one male and one female), 5 male interviewers, 5 female interviewers and one cook/logistical assistant. But, subsequently, it was found that controlling the field work would be very difficult with an interviewing team of 10 members. Consequently, the decision was taken to organize the interviewing group into smaller teams as described above.

There was one quality control team to check the work done by the interviewers and enumerators. The quality control team was made up of one male quality control officer and one female quality control officer. In addition, senior executives of Mitra and Associates made several field visits to ensure that the field work was done properly.

Categorization of Open-ended Questions:

There were 58 open-ended questions asked in the provider questionnaire and 57 in the user questionnaire. An open-ended question was designed to collect the entire range of information that respondents had about a certain thing or subject. Categorisation and coding of answers to open-ended questions were done following six steps. Step-1, identify and separate out all possible answers given to an open-ended question; step-2, develop categories combining all over-lapping answers together, under a common category; step-3, evaluate the weight of a category by studying the relative frequency of answers (if the category was found rarely mentioned, it was merged with the category 'other'); step-4, classify the categories in some major groups, labelling each major group as a net code and the categories making the major group as its subnet codes; step-5, review before the categorisation scheme was finally adopted; and step-6, code answers to the open-ended questions.

Data Processing:

This task comprised office editing, transferring of coded information, preparation of key tables and computer work.

Office editing was done to verify that the questionnaires were correctly filled in, that the correct respondent had been interviewed, that items of information recorded or responses to questions obtained were consistent with one another in each of the filled in questionnaires, that all questions in a questionnaire were asked, etc. Editing was done by two groups. Each group comprised one editor, one edit verifier and one project officer. While the editor did the initial editing work, the edit verifier checked 100 percent of the edit work to ensure that it was done correctly. The project officer in each group checked 10 percent of the work done by the edit verifier. The two groups worked for about one month to complete the editing work.

Coded information in the questionnaire was transferred onto code cards by employing 6 coders and 6 coding verifiers for about two months. There were 12 code cards used for the user questionnaire and 10 code cards for the provider questionnaire. As such, there were, in all, 12,390 code cards used to transfer the data from the questionnaires. Two project officers each checked 10 percent of the code transferring work to ensure that the transferring was done correctly.

More than 100 key tables were manually prepared by sorting code cards. A team of 5 members was employed for the preparation of the key tables. This team worked for about one and a half months. Senior professionals of Mitra and Associates checked the tabulation work to ensure accuracy.

Computer Work:

The Bangladesh University of Engineering and Technology IBM computer was used to put the data onto computer tapes. There were two computer programmers employed for the computer work. First, data from each deck of code cards were entered into the computer disk, using an independent data-file. As such, there were 12 data files used for the user/husband questionnaire, and 10 data files for the provider questionnaire. Validation checks were performed by manually comparing data print-out with the code cards. Errors detected during the validation checks were removed before the data from all the files for the user/husband questionnaire were put into one tape and those for the provider questionnaire into a second tape. For evidence that the tapes are clean, some tables were brought out using the tapes and compared with the corresponding key tables which were prepared manually.

APPENDIX A - TABLES

TABLE 1.1 -- Frequency distribution of providers' characteristics by type of provider

	N=	PROVIDER			
		DOC %	HP %	PHAR %	ALL %
<hr/>					
Urban or rural residence					
Urban		51	41	41	45
Rural		49	59	59	55
Total		100	100	100	100
<hr/>					
Age (completed years)(P106)					
20 - 29		20	33	52	33
30 - 39		44	29	31	35
40 - 49		9	14	14	12
50 or over		27	25	3	20
Total		100	100	100	100
<hr/>					
Married (P107)					
Yes		87	94	83	89
No		13	6	17	11
Total		100	100	100	100
<hr/>					
Religion (P108)					
Islam		84	82	86	84
Hindu		16	18	14	16
Total		100	100	100	100
<hr/>					
Education completed (P109)					
High school		4	49	38	30
Intermediate college		0	25	28	16
College grad.		0	12	34	13
Medical degree		96	12	0	40
Other		0	2	0	1
Total		100	100	100	100
<hr/>					

TABLE 1.1 (continued)

	N=	PROVIDER			
		DOC	HP	PHAR	ALL
		45	49	29	123
		%	%	%	%
<hr/>					
Main occupation (P110)					
Advising/prescribing		100	86	21	76
Selling medicines		0	14	79	24
Total		100	100	100	100
<hr/>					
This occupation is full time (P111)					
Yes		91	90	97	92
No (Part time)		9	10	3	8
Total		100	100	100	100
<hr/>					
Mean number of years in this occupation (P112)					
		7	9	8	8
<hr/>					

TABLE 1.2 -- Frequency distribution of characteristics
of current users by type of provider

	N=	PROVIDER			
		DOC	HP	PHAR	ALL
		45	49	29	123
		%	%	%	%
Urban or rural residence					
Urban		54	37	42	44
Rural		46	63	58	56
Total		100	100	100	100
<hr/>					
Married and living together		100	100	100	100
<hr/>					
Religion					
Islam		92	86	80	87
Hindu		8	14	20	13
Total		100	100	100	100
<hr/>					
Age (C107)					
Under 20		16	9	10	13
21 - 35		75	81	83	79
Over 35		9	10	7	8
Total		100	100	100	100
<hr/>					
Mean age at marriage (completed years) (C106)		15	15	15	15
<hr/>					
Mean duration of marriage (completed years) (C101)		11	13	10	12
<hr/>					

TABLE 1.2 (continued)

	N=	PROVIDER			
		DOC	HP	PHAR	ALL
		45	49	29	123
		%	%	%	%
Ever give birth (C601)					
Yes		93	99	94	96
No		7	1	6	4
Total		100	100	100	100
Number of children ever born (C607)					
0		7	1	6	4
1		16	8	19	13
2		25	21	32	25
3		14	26	13	19
4		19	12	15	15
5		8	13	9	10
6		8	6	1	6
More than 6		5	12	6	8
Total		100	100	100	100
Mean		3	4	3	3
25th centile	2				
50th centile	3				
75th centile	4				
Number of child deaths (C606)					
1		16	24	16	19
2		9	6	2	6
3 - 4		1	3	2	2
Not applic.		74	67	80	73
Total		100	100	100	100
Number of living children (C604)					
0		7	1	7	5
1		17	10	18	15
2		30	28	33	29
3		16	24	16	20
4		15	18	15	16
5		8	6	7	6
More than 6		7	13	4	9
Total		100	100	100	100

TABLE 1.2 (continued)

	N=	PROVIDER			
		DOC	HP	PHAR	ALL
		45	49	29	123
		%	%	%	%
Age of youngest living child (C610)					
YEARS					
Less than 1		5	5	5	5
1 - 2		15	12	14	14
2 - 3		26	22	14	22
3 - 4		16	17	17	16
4 - 5		7	12	19	12
5 - 6		5	7	9	7
6 - 7		8	5	6	6
7 and over		11	19	9	14
Not applic.		7	1	7	5
Total		100	100	100	100
Any pregnancies since youngest child born (C617)					
Yes		5	8	9	7
No		88	91	84	88
Not applic.		7	1	7	5
Total		100	100	100	100
Status of that pregnancy (C619)					
Live birth		0	1	1	1
Abortion		2	3	6	4
Still birth		2	1	0	1
Infant death		0	1	1	1
No response		0	1	0	1
Not applic.		96	93	92	92
Total		100	100	100	100
Currently pregnant (C618)					
Yes		2	2	3	2
No		11	7	12	10
Not applic.		88	91	84	88
Total		100	100	100	100

TABLE 1.2 (continued)

	N=	PROVIDER			
		DOC	HP	PHAR	ALL
		45	49	29	123
		%	%	%	%
<hr/>					
Attended school (C108)					
Yes		83	77	87	81
No		17	23	13	19
Total		100	100	100	100
<hr/>					
Highest level completed (C110)					
None		18	23	14	19
Primary		36	30	20	30
6 - 9		27	29	42	31
High school		15	17	23	18
University/Professional		4	1	1	2
Total		100	100	100	100
<hr/>					
Currently employed (C112)					
Yes		8	12	12	10
No		92	88	88	90
Total		100	100	100	100
<hr/>					
Income from employment (C113)					
Yes		8	11	11	10
No		0	1	1	1
Not applic.		92	88	88	89
Total		100	100	100	100
<hr/>					
Husband's family owns land (C115)					
Yes		77	81	81	79
No		23	19	19	21
Total		100	100	100	100

TABLE 1.2 (continued)

	N=	PROVIDER			
		DOC	HP	PHAR	ALL
		45	49	29	123
		%	%	%	%
Television in household (C116)					
Yes		26	15	27	21
<hr/>					
Ever watched television (C117)					
Yes		85	80	91	84
<hr/>					
Radio in household (C118)					
Yes		62	62	66	63
<hr/>					
Ever listened to radio (C119)					
Yes		95	97	97	96
<hr/>					

TABLE 1.3 -- Frequency distribution of characteristics
of current users husbands by type of provider

	N=	PROVIDER			
		DOC	HP	PHAR	ALL
		129	147	89	365
		%	%	%	%
<hr/>					
Urban or rural residence					
Urban		54	40	42	45
Rural		46	60	58	55
Total		100	100	100	100
<hr/>					
Married and living together		100	100	100	100
<hr/>					
Religion (C111)					
Islam		92	86	80	87
Hindu		8	14	20	13
Total		100	100	100	100
<hr/>					
Age (C107)					
Under 20		16	9	10	13
21 - 35		75	81	83	79
Over 35		9	10	7	8
Total		100	100	100	100
<hr/>					
Mean age at marriage (completed years) (C106)		25	24	24	24
<hr/>					
Mean duration of marriage (completed years) (C101)		11	13	10	12
<hr/>					
Attended school (C108)					
Yes		89	91	99	92
No		11	9	1	8
Total		100	100	100	100
<hr/>					

TABLE 1.3 (continued)

	N=	PROVIDER			
		DOC	HP	PHAR	ALL
		129	147	89	365
		%	%	%	%
Highest level completed (C110)					
None		12	9	1	9
Primary		14	14	11	13
6 - 9		21	22	22	21
High school		33	40	39	37
University/Professional degree		20	15	27	20
Total		100	100	100	100
Occupation (C114)					
Agriculture		18	27	7	19
Business/Trade		43	45	61	48
Service/Government		36	26	29	31
Professional		3	2	3	2
Total		100	100	100	100
Family owns land (C115)					
Yes		75	83	76	79
Television in household (C116)					
Yes		26	14	29	22
Ever watched television (C117)					
Yes		83	82	90	84
Radio in household (C118)					
Yes		60	66	73	65
Ever listened to radio (C119)					
Yes		95	93	97	95

RETAILING AND PURCHASING PATTERNS

TABLE 2.1 -- Frequency distributions of providers' stocking and selling patterns, by type of provider

	PROVIDERS			
	DOC	HP	PHAR	ALL
N=	45	49	29	123
	%	%	%	%
Number of years since SMP OCs first stocked (P213)				
YEARS				
1 or less	22	31	10	22
1 - 2	15	14	14	14
2 - 3	2	20	28	15
3 - 4	15	6	3	8
4 - 6	12	8	21	13
6 - 7	2	6	3	4
7 or more	17	15	22	19
Not stocked/not stated	15	0	0	5
Total	100	100	100	100

Number of cycles sold in last 4 weeks (P206)				
Less than 10	48	29	0	29
10 - 19	20	19	14	18
20 - 29	14	21	7	15
30 - 39	7	2	7	5
40 - 49	4	9	7	7
50 - 99	5	10	36	12
100 or more	2	10	29	14
Total	100	100	100	100

Brand names usually stocked (P201)				
Maya	60	92	13	78
Ovacon	76	82	100	84
Ovostat	76	84	97	84
Restovar	20	20	35	24
Noriday	27	6	3	13
Comb-5	11	2	3	6
Lyndiol	47	51	76	55

TABLE 2.1 (continued)

	PROVIDERS			
	DOC N= 45 %	HP 49 %	PHAR 29 %	ALL 123 %
Number of brands usually stocked (P202)				
One	7	8	0	5
Two	26	12	3	15
Three	27	33	24	29
Four	29	27	45	32
Five	11	18	28	19
Six	0	2	0	0
Total	100	100	100	100
<hr/>				
Brand most often sold (P203)				
Maya	15	29	14	20
Ovacon	22	31	10	23
Ovostat	38	35	76	46
Noriday	11	0	0	4
Other	13	6	0	7
Total	100	100	100	100
<hr/>				
Major reasons for selling that brand (P204, P205)				
Low dose	33	6	0	15
Few side effects	60	53	55	56
High demand	13	20	59	27
Cheap	22	43	21	30
Most suitable for customer	22	16	40	24
Reliable	18	33	14	23
Readily available	20	10	3	12
Regulates menses	7	12	3	8
Free of charge	13	0	0	5
Other	11	22	20	18

RETAILING AND PURCHASING PATTERNS
 TABLE 2.2 -- Frequency distributions or type of usual purchaser,
 by type of provider

	PROVIDERS			
	DOC	HP	PHAR	ALL
N=	45	49	29	123
	%	%	%	%
Type of usual purchaser (P211)				
User herself	56	16	14	30
Husband	44	84	86	70
Total	100	100	100	100

	USERS				HUSBANDS			
	DOC	HP	PHAR	ALL	DOC	HP	PHAR	ALL
Usual purchaser (C201)								
Self	32	40	15	31	64	64	83	69
Spouse	65	60	84	68	33	36	16	30
Other	3	1	1	2	3	0	1	1
Total	100	100	100	100	100	100	100	100

Supplies procured or delivered (C206)								
Usually procured by us	77	72	90	78	74	69	91	76
Delivered by FP	22	27	9	21	23	29	9	22
Other	3	1	1	1	3	2	0	2
Total	100	100	100	100	100	100	100	100

RETAILING AND PURCHASING PATTERNS

TABLE 2.3 -- Frequency distributions of brand purchasing habits by responses of users and husbands

	USERS				HUSBANDS			
Number of brands ever used (C215)								
One	47				45			
Two	33				35			
More than two	20				20			
Total	100				100			

Name of usual brand (C214)	USERS				HUSBANDS			
	DOC	HP	PHAR	ALL	DOC	HP	PHAR	ALL
Maya	5	10	10	8	3	11	10	8
Ovacon	5	8	3	5	6	6	7	6
Ovostat	14	15	23	16	14	14	20	15
Noriday	20	13	1	13	20	8	1	11
Other	5	3	4	4	5	1	5	4
Not applic.	52	51	58	54	51	60	58	56
Total	100	100	100	100	100	100	100	100

	USERS		HUSBANDS	
Different brands used (C216)				
Maya	22		29	
Ovacon	24		23	
Ovostat	40		42	
Noriday	17		15	
Lyndiol	18		19	
Others	6		8	
Not applic.	47		45	
Total	100		100	

	USERS		HUSBANDS	
Brand preferred by user (C217)				
Maya	3		4	
Ovacon	9		9	
Ovostat	21		23	
Noriday	6		5	
Other	10		10	
Don't know	4		4	
Not applic.	47		45	
Total	100		100	

TABLE 2.3 (continued)

	USERS	HUSBANDS
Reasons for user's preference (C218)		
Effectiveness	6	9
Few side-effects	74	75
Provider advised it	5	4
Free of cost	12	10
Other	3	1
Not applic.	4	3
<hr/>		
Packet identified (C219)		
Maya	25	31
Ovacon	30	30
Ovostat	56	56
Other	56	56
Don't know	1	1
<hr/>		

TABLE 2.4 -- Frequency distribution of sources of supply, by users and husbands responses

	USERS				HUSBANDS			
	DOC	HP	PHAR	ALL	DOC	HP	PHAR	ALL
	%	%	%	%	%	%	%	%
Provider of first pack (C225)								
Doctor	12	5	11	9	19	5	6	10
Health Professional	5	14	4	8	4	17	10	11
Pharmacist	38	26	54	37	40	34	68	45
Family Planning Worker	31	37	19	31	35	38	15	31
Other	3	6	2	4	1	6	0	3
Don't know	11	12	10	11	2	0	1	1
Total	100	100	100	100	100	100	100	100

	DOC	HP	PHAR	ALL
	%	%	%	%
Where most customers would go to buy more OCs (P212)				
Me, myself	69	78	83	76
My assistant	11	2	0	5
Other place	13	12	7	11
Don't know	7	8	10	8
Total	100	100	100	100

	USERS				HUSBANDS			
	DOC	HP	PHAR	ALL	DOC	HP	PHAR	ALL
	%	%	%	%	%	%	%	%
Usual provider (C203)								
Doctor	12	4	5	7	18	2	0	7
Health Professional	3	16	6	9	2	20	8	11
Pharmacist	36	27	64	39	40	36	79	48
Family Planning Worker	32	33	14	28	32	35	10	28
Clinic/Other	5	9	1	5	8	6	3	6
Not applic.	12	12	11	12	0	0	0	0
Total	100	100	100	100	100	100	100	100

TABLE 2.4 (continued)

	USERS				HUSBANDS			
	DOC %	HP %	PHAR %	ALL %	DOC %	HP %	PHAR %	ALL %
Reason for choosing the usual provider (C226)								
More easily available	6	10	9	8	7	12	6	9
Prefer free-of-cost (government)	3	5	2	4	8	8	3	7
Doctor's advice/Other	1	2	5	2	4	5	8	5
Not applic.	90	83	84	86	81	75	83	79
Total	100	100	100	100	100	100	100	100

Ever obtained from another provider (C204)								
Yes	18	21	28	21	41	55	52	49
No	70	64	55	64	57	43	45	48
Don't know	0	3	6	3	2	2	3	3
Not applic.	12	12	11	12	0	0	0	0
Total	100	100	100	100	100	100	100	100

Other providers (C205)								
Doctor	1	1	2	1	6	1	1	3
Health Professional	1	2	1	1	0	4	2	2
Pharmacist	5	7	7	7	27	37	33	32
Family Planning Worker	6	8	14	9	3	9	12	8
Clinic	2	1	2	2	2	5	0	2
Other	3	1	1	1	2	2	3	2
Not applic.	82	79	72	78	59	46	48	51
Total	100	100	100	100	100	100	100	100

	N=	USERS 365 %	HUSBANDS 365 %
Duration of time since first use (C424)			
Mean number of months		51	57
Total		100	100

TABLE 2.5 -- Frequency distributions of availability of oral contraceptives by reponses of users and husbands

	USERS	HUSBANDS
Method of travel to the provider (C207)		
Walk	47	55
Ride	29	21
Don't know	2	0
Not applic.	22	24
Total	100	100
Travel time to the provider (C208)		
Less than 10 min.	47	49
10 - 19 min.	14	16
20 - 29 min.	6	4
30 min. or more	6	7
Don't know	5	0
Not applic.	22	24
Total	100	100
Difficulty of travelling to the provider (C209)		
Difficult	10	6
Not difficult	68	70
Don't know	1	0
Not applic.	21	24
Total	100	100
Availability of OCs at that place (C210)		
Available always	94	90
Sometimes unavailable	6	9
Don't know	0	1
Total	100	100

TABLE 2.5 (continued)

	USERS	HUSBANDS
Reasons for non-availability (C211)		
Out of stock	2	7
Not regularly delivered	3	1
Other	0	1
Not applicable	95	92
Total	100	100

Suggested improvements for supply
(C212)

Home delivery	52	60
Ensure stocks	10	22
Lower price	2	5
Other	4	7
Don't know	32	6
Total	100	100

TABLE 2.6 -- Frequency distribution of multiple purchasing and stocking, by responses of users and husbands

	USERS	HUSBANDS
Another pack is usually purchased before current pack finished (C220)		
Yes	39	40
No	61	58
Don't know	0	2
Total	100	100

Ever purchased more than one packet at a time (C221)		
Yes	48	44
No	52	53
Don't know	0	3
Total	100	100

Opinion on advisability of buying two packets at a time (C222)		
Good idea	75	88
Bad idea	20	12
Don't know	5	0
Total	100	100

	PROVIDERS			
	DOC	HP	PHAR	ALL
	N= 45	49	29	123
	%	%	%	%
Good idea for a starting couple to buy more than one packet (P209)	100	94	90	95

A starting couple would be willing to buy more than one packet (P210)				
Yes	58	35	17	39
No	42	65	83	61
Total	100	100	100	100

TABLE 2.6 (continued)

	USERS	HUSBANDS
Willingness to purchase two packets when beginning (C223)		
Willing	59	40
Unwilling	30	55
Don't know	11	5
Total	100	100

Willingness of continuing users to purchase two packets (224)

Willing	68	63
Unwilling	18	34
Don't know	14	3
Total	100	100

TABLE 3.1 -- Relationship with oral contraceptive customers
 III- Instructors and instructions by provider.

		PROVIDER			
N=		DOC	HP	PHAR	ALL
		%	%	%	%
Which spouse first discussed OCs with (P305).					
	Wife	33	14	7	19
	Husband	65	86	93	80
	Other	2	0	0	1
	Total	100	100	100	100
<hr/>					
Customers usually know or ask advice on which method to use (P301).					
	Usually know	33	12	55	30
	Usually ask	67	88	45	70
	Total	100	100	100	100
<hr/>					
Method usually suggested (P303).					
	OC	64	76	76	72
	Condom	2	6	10	6
	Sterilization	16	14	3	12
	IUD	16	4	3	8
	Other	2	0	7	3
	Total	100	100	100	100
<hr/>					
Couples' first OC knowledge source (P304).					
	Me, myself	16	49	45	36
	Some other source	82	51	55	64
	Don't know	2	0	0	0
	Total	100	100	100	100

TABLE 3.2 -- Sources of knowledge to the couple.
 III - Instructors and instructions.

N =	USER				HUSBAND			
	DOC	HP	PHAR	ALL	DOC	HP	PHAR	ALL
	45	49	29	123	45	49	29	123
	%	%	%	%	%	%	%	%
Sources of most knowledge to the user (C301).								
Fam plan worker	29	35	17	28	31	37	18	30
Fam plan officer	0	0	0	0	2	1	2	2
Doctor	6	1	0	1	17	8	10	12
HP	2	5	1	3	2	10	6	6
Husband	41	44	55	46	27	30	40	31
Packet insert	4	5	14	7	9	4	11	8
Radio	1	0	1	1	2	1	1	1
Relative/Neighbor/ Friend	17	10	10	12	4	3	2	3
Shop/other	0	1	0	0	2	3	3	3
Don't know	0	0	0	0	0	1	1	1
<hr/>								
Other sources (C302)								
None	76	77	72	75	67	56	60	61
Fam plan worker	5	8	7	7	8	13	11	11
Husband	6	6	11	7	2	6	3	4
Doctor	0	2	1	1	5	6	6	6
Relative/Friend/ Neighbor	8	5	5	6	7	6	8	7
Insert	5	0	3	3	5	2	2	3
Shop/Other	0	0	0	0	3	0	2	2
Don't know	0	0	0	0	5	10	8	8

TABLE 3.2 (continued)

	N =	USER				HUSBAND			
		DOC	HP	PHAR	ALL	DOC	HP	PHAR	ALL
		45	49	29	123	45	49	29	123
		%	%	%	%	%	%	%	%
Quantity of interspousal communication before ever-use (C303).									
Very much		17	19	15	17	29	29	36	31
Quite a lot		22	27	19	23	17	23	26	22
Not much		38	31	36	35	39	27	21	30
Only a little		22	19	28	22	12	14	15	13
Not at all		2	3	2	3	4	8	2	5
Total		100	100	100	100	100	100	100	100
Instructed by first provider when first packet obtained (C304).									
Yes		37	45	26	38	53	55	36	50
No		61	53	71	60	41	40	61	45
Don't know		2	2	3	2	6	5	3	5
Total		100	100	100	100	100	100	100	100
First instructor, if not first provider (C305).									
Husband		40	42	52	43	21	21	34	24
Insert		2	3	10	4	3	1	3	3
Fam plan worker		1	2	0	1	5	2	11	7
Relative/Friend		14	5	9	9	5	5	6	5
Doctor		3	1	0	2	4	5	7	5
Other		1	0	0	1	2	0	0	1
Don't know									
Not applicable		39	47	29	40	59	60	40	55
Not stated		0	0	0	0	1	0	0	0
Total		100	100	100	100	100	100	100	100

TABLE 3.3 -- Instructions about which pill should be taken first. III-Instructors and instructions

	PROVIDERS					
	DOC	HP	PHAR	ALL	USER	HUSB
N=	45	49	29	123	365	365
	%	%	%	%	%	%
Instruction was given (P309, C309)						
Yes	96	96	93	95	88	76
No	4	4	7	5	12	18
Don't know	0	0	0	0	0	6
Total	100	100	100	100	100	100
Wether told or shown (P310, C310)						
Told	24	16	14	19	5	15
Shown	72	80	79	76	83	61
Not applic.	4	4	7	5	12	24
Total	100	100	100	100	100	100
Actual instruction given (P311, C311)						
Marked by arrow	11	6	3	7	2	4
Other	13	10	11	12	3	11
Not applic.	76	84	86	81	95	85
Total	100	100	100	100	100	100
Pointed to first pill (P312, C312)						
Correctly	89	75	86	83	90	79
Incorrectly	11	25	14	17	10	11
Don't know	0	0	0	0	0	10
Total	100	100	100	100	100	100

TABLE 3.4 -- Instructions about which day the user should take the first pill

	PROVIDERS				USER	HUSB
	DOC	HP	PHAR	ALL		
N=	45	49	29	123	365	365
	%	%	%	%	%	%
Instructions given (P306, C306)						
Yes	96	98	97	97	92	77
No	4	2	3	3	8	13
Don't know	0	0	0	0	0	9
Total	100	100	100	100	100	100

Type of instructions given (P307, C307).						
Menses day 1	27	31	7	24	7	10
Menses day 5	29	27	21	26	47	30
Menses day 6	0	0	0	0	12	3
End of menses	9	12	7	10	16	15
Per instructions	9	6	17	10	1	3
By brand	18	4	38	17	0	0
Other	2	4	0	2	9	10
Not applic.	4	2	3	3	8	21
Don't know	0	0	0	0	0	8
Total					100	100

When first pill should be given (P308, pC308)		
Menses day 1		8 15
Menses day 5		50 34
Menses day 6		12 3
End of menses		17 23
Per packet		2 3
Other		10 13
Don't know		1 9
Total		100 100

TABLE 3.5 -- Instructions about time of day

	PROVIDERS					
	DOC	HP	PHAR	TOTAL	USER	HUSB
N=	45	49	29	123	365	365
	%	%	%	%	%	%
Instructions were given (P316, C316)						
Yes	100	98	93	98	92	80
No	0	2	7	2	8	12
Don't know	0	0	0	0	0	8
Total	100	100	100	100	100	100
<hr/>						
Type of instructions (P317, C317)						
Bedtime	82	92	86	87	91	78
Morning	9	2	3	5	0	0
Any specified time of day	7	2	4	4	1	1
Other	0	2	0	1	0	1
Not applicable	0	2	7	2	8	20
Not stated	2	0	0	1	0	0
Total	100	100	100	100	100	100
<hr/>						
Importance of daily routine (P318, C318)						
Important	100	98	100	99	97	97
Not important	0	2	0	1	1	2
Don't know	0	0	0	0	2	1
Total	100	100	100	100	100	100

TABLE 3.6 -- Instructions about daily continuation

	PROVIDERS					
	DOC	HP	PHAR	TOTAL	USER	HUSB
N=	45	49	29	123	365	365
	%	%	%	%	%	%
Instruction was given (P313, C313)						
Yes	96	94	86	93	85	74
No	4	6	14	7	14	19
Don't know	0	0	0	0	0	7
Not stated	0	0	0	0	1	0
Total	100	100	100	100	100	100
Type of instruction (P314, C314)						
One every day, etc.	67	61	59	63	70	52
One daily as per arrow	22	18	21	20	13	14
Per packet instruction	2	12	7	7	3	5
Other	2	2	0	0	0	0
Not applicable	4	6	14	7	14	26
Not stated	3	0	0	0	0	0
Don't know	0	0	0	0	0	3
Total	100	100	100	100	100	100
When should pills be taken (P315, C315)						
Every day, etc.	7	6	14	8	11	16
Daily, as per arrow	0	0	0	0	2	0
As instructed	0	0	0	0	1	0
Other	0	0	0	0	0	10
Not applicable	93	94	86	92	86	74
Don't know	0	0	0	0	0	6
Total	100	100	100	100	100	100

TABLE 3.7 -- Instructions about when the next packet should be started

	PROVIDERS			TOTAL	USER	HUSB
	DOC	HP	PHAR			
N=	45	49	29	123	365	365
	%	%	%	%	%	%
Instructions were given (P319, C319)						
Yes	93	92	79	89	85	76
No	7	8	21	11	15	18
Not applicable	0	0	0	0	0	6
Total	100	100	100	100	100	100
Type of instructions (P320, C320)						
1st menstrual day	22	25	14	21	4	6
5th menstrual day	27	18	17	21	35	24
After finishing						
current package	24	24	3	20	15	23
Per packet instructions	7	0	7	4	2	3
On the 1st or 5th						
day, according to brand	2	2	24	7	0	0
At end of menstruation	4	12	7	8	13	10
Other	2	4	0	2	16	7
Don't know	0	0	0	0	0	3
Not applicable	4	8	21	10	15	24
When second pack should be started (P321, C321)						
1st menstrual day	1	0	3	1	0	0
5th menstrual day	0	2	3	2	7	7
After finishing						
current package	0	0	0	0	3	3
Per packet instructions	2	4	3	3	0	0
On the 1st or 5th						
day, according to brand	0	0	3	1	0	0
At end of menstruation	0	0	7	2	0	2
Other	4	2	2	2	5	6
Don't know	0	0	0	0	0	7
Not applicable	93	92	79	89	85	75
Total	100	100	100	100	100	100

TABLE 3.9 -- Additional instructions given, by responses of providers, users and husbands

	DOC N= 45 %	PROVIDER			USER 365 %	HUSB 365 %
		HP 49 %	PHAR 29 %	ALL 123 %		
Whether other instructions given (P322, C322)						
Yes	91	86	62	82	20	19
No	9	14	38	18	77	65
Don't know					3	16
Total	100	100	100	100	100	100
<hr/>						
Other instructions/information (spontaneous) (P323, C323)						
No	9	14	38	18	77	65
Nausea/dizziness	60	35	31	43	4	8
May cause menstrual change/scanty menstruation	18	16	21	18	1	1
Take pills regularly	20	25	21	22	3	2
Take two if one forgotten	20	10	7	13	4	2
<hr/>						
Whether instructions on "forgetting" given/received (asked if not offered in 323) (P324, C324)						
Yes	76	82	83	80	77	70
No	4	6	7	6	14	17
Don't know	0	0	0	0	0	9
Not applic.	20	12	10	14	9	4
Total	100	100	100	100	100	100

TABLE 3.9 (continued)

	DOC N=	PROVIDER			USER	HUSB
		HP	PHAR	ALL		
	45	49	29	123	365	365
	%	%	%	%	%	%
Instructions given about forgetting a pill (P325, C326)						
Take two next day	35	47	43	41	49	
Take it when remembered	11	4	17	10		
Take it next morning	9	6	7	7	16	
Take it as soon as possible	20	18	14	18	20	
Other	2	6	3	3		
Not applic.	22	18	17	20	14	
Total	100	100	100	100	100	
Beliefs about correct response to forgetting						
Take two next night	7	6	3	6	8	11
Take it when remembered	7	4	10	7	2	4
Take one next morning	2	2	3	2	1	3
Other	6	10	1	4	3	8
Not applic.	78	82	83	81	86	74
Total	100	100	100	100	100	100
When were these instructions first received? (C325) (asked only of couples who answered "Yes" to C324)						
Before first pills used					65	55
Later					12	13
Can't recall					0	1
Not applic.					23	31
Total					100	100
Whether instructions given about side effects (P330, C328)						
Yes	89	94	83	89	43	43
No	11	6	17	11	57	42
Don't recall/ don't know	0	0	0	0	0	15
Total	100	100	100	100	100	100

TABLE 3.9 (continued)

	DOC N=	PROVIDER			USER 365 %	HUSB 365 %
		HP 49 %	PHAR 29 %	ALL 123 %		
Instructions given about other effects (P331, C329)						
Health effects (net)	89	90	79	87	42	42
Nausea/dizziness	71	43	62	58	26	19
Headache	29	27	21	26	39	36
Weakness	13	45	24	29	7	18
Pain in limbs	11	10	17	12	2	4
Other minor health effects	16	37	31	28	13	18
Menstrual changes (irregular, scanty, heavy, spotting, etc.)	38	26	31	32	13	9
<hr/>						
When above instructions first received (C330)						
Before use					36	34
Later					6	9
Can't recall					0	1
Not applic.					58	56
Total					100	100
<hr/>						
Whether instructed on nausea/ dizziness/stomach upset side effects before first use (C331)						
Yes					37	41
No					61	48
Don't recall					2	11
Total					100	100
<hr/>						
Type of advice given (C332)						
Take certain foods					17	15
Continue with pills					12	15
Consult provider					5	8
Stop pills/switch method					3	5

TABLE 3.9 (continued)

	USER	HUSB
	365	365
	%	%
Whether instructed on possible menstrual changes before first use (C333)		.
Yes	30	25
No	62	53
Don't recall	1	17
Not applic.	7	5
Total	100	100
<hr/>		
Type of advice given (C334)		
Take certain foods	1	1
Continue pills	16	13
Consult provider	5	4
Stop pills/switch method	1	1
<hr/>		

TABLE 3.10 -- Frequency distribution of interpersonal communications by responses of user and husbands of users

	N=	USER 365 %	HUSB 365 %
Ever had a question that needed answering (C338)			
Yes		27	40
No		73	58
Don't recall		0	2
Total		100	100
<hr/>			
Whether discussed with spouse (C339)			
Yes		25	40
No		2	0
Not applic.		73	60
Total		100	100
<hr/>			
Whether discussed with other people (C340)			
Yes		13	22
No		14	17
Not applic.		73	61
Total		100	100
<hr/>			
Type of person discussed with (C341)			
Family planning worker		2	7
Doctor		7	13
Other providers		0	0
Relatives/friends/neighbors/others		4	0
Not applic.		87	78
Total		100	100

TABLE 3.10 (continued)

	USER	HUSB
N=	365	365
	%	%
Would discuss future questions with spouse (C342)		
Yes	98	98
No	1	1
Don't know	1	1
Total	100	100
<hr/>		
Other people such questions would probably be discussed with (C343)		
Family planning worker	17	21
Doctor	38	69
Relative	5	1
Neighbor	4	6
None	30	8
Don't know	8	1
Total	100	100
<hr/>		
Would seek advice on family planning from whom (C518)		
Graduate doctor	1	16
Pharmacist	0	1
Health professional	0	3
Doctor	41	38
Government doctor	10	17
Family planning worker	14	15
Family planning clinic	3	8
Husband	26	0
Relative	2	0
Don't know	1	0
Total	100	100

TABLE 4.1 -- Frequency distributions of aspects of continuity, by users and husbands of users

	USER	HUSB
N=	365	365
	%	%
Duration of time since first use (C424)		
Mean number of months	51	57

Whether use was continuous since that time (C425)		
Yes	50	47
Stopped for one month or more	50	51
Don't know	0	2
Total	100	100

	USERS		
	DOC	HP	PHAR
	%	%	%
Duration of first use (C426)			
Mean number of months	8	17	17

Reasons for discontinuing the first time (C427)		
Health	10	15
Menstrual changes	3	3
To have a child	16	17
Pregnancy	4	4
Husband away	1	1
Visiting family	3	2
Switch method	6	8
Other		
Not applic	50	50
Total	100	100

TABLE 4.1 (continued)

	N=	USER 365 %	HUSB 365 %
Whether user began use a second time (C428)			
Started again		45	49
Never used again		4	2
Don't know		0	0
Not applic.		51	49
Total		100	100
<hr/>			
Whether use was continuous since that time (C430)			
Yes		30	25
No		15	22
Don't know		0	2
Not applic.		55	51
Total		100	100
<hr/>			
Whether began a third time (C433)			
Yes		14	21
No		1	1
Not applic.		85	78
Total		100	100
<hr/>			
Whether taking since that time (C434)			
Yes		6	10
No		8	12
Not applic.		86	78
Total		100	100
<hr/>			
Number of additional times stopped since then (C435)			
One to three times		7	11
Don't know		1	1
Not applic.		92	88
Total		100	100

TABLE 4.2 -- Frequency distributions of current use, by responses of users and husbands of users

	N=	USER 365 %	HUSB 365 %
Whether using OCs currently (C440)			
Yes		93	94
No		2	3
Not applic.		5	3
Total		100	100
<hr/>			
Intention to continue (C441)			
Yes		87	83
No		3	6
Maybe		3	6
Don't know		7	5
Total		100	100
<hr/>			
Reason (C442)			
No more children wanted		64	63
Delay pregnancy		15	11
Prefer OCs		11	13
<hr/>			
OCs injurious		3	5
Prefer another method		7	8
Total		100	100
<hr/>			

TABLE 4.3 -- Frequency distributions of
current status of pills

		USERS			
	DOC	HP	PHAR	ALL	
N =	45	49	29	123	
	%	%	%	%	
Whether OCs currently in the household (C443)					
Yes	84	84	81	83	
No	15	15	19	16	
Don't know	1	1	0	1	
Total	100	100	100	100	

Reason for not having OCs in the household (C444)					
Package finished	7	5	6	6	
Menstruating	2	3	3	3	
Other	2	2	1	1	
Not applic.	89	91	90	90	
Total	100	100	100	100	

Status of the packet (C445)					
Full	5	2	1	3	
Empty	11	11	10	11	
Partly full and correctly used	66	68	68	67	
Partly full but not correctly used	2	3	2	2	
Not applic.	16	16	19	17	
Total	100	100	100	100	

TABLE 4.4 -- Frequency distribution of users' compliance policies

	USERS			
	DOC	HP	PHAR	ALL
N =	45	49	29	123
	%	%	%	%
Whether would take pill when husband away (C448)				
Stops	5	9	3	6
Continues	95	91	97	94
Total	100	100	100	100

Intention is always to take one only per day (C449)				
Yes	98	99	99	99
Other/Don't know	2	1	1	1
Total	100	100	100	100

TABLE 4.5 -- Frequency distributions of perceived
 contraindications, as reported by type of provider

	PROVIDERS			
	DOC	HP	PHAR	TOTAL
N=	45	49	29	123
	%	%	%	%
Believes all women can take OCs safely (P419)				
Yes	4	10	35	14
No	96	90	65	86
Total	100	100	100	100

Women for whom pills contraindicated (P420)				
Hypertension	47	32	24	30
Cancer	36	18	17	24
Ulcer	9	33	24	22
Diabetes	38	16	7	22
Anemia	13	20	17	17
Jaundice	29	8	7	22
Tuberculosis	2	20	14	12
Menstrual	9	16	13	11
Not applic.	4	10	35	14

Believes that breastfeeding is a contraindication (P421)				
Yes	78	51	62	63
No	22	35	24	28
Don't know	0	14	14	9
Total	100	100	100	100

TABLE 4.6 -- Frequency distributions of reasons for discontinuation,
as reported by type of provider

	PROVIDERS			
	DOC	HP	PHAR	TOTAL
N=	45	49	29	123
	%	%	%	%
Reasons (P425)				
Health problems	91	71	75	77
Put on weight	9	10	17	11
Menstrual irregularities	20	8	17	15

Whether the provider's patient/
customer has become pregnant
while using OCs (P426)

Yes	24	24	31	26
No	69	69	65	68
Don't know	7	7	3	6
Total	100	100	100	100

Number of users who have
become pregnant (P427)

One	7	2	10	6
Two	9	16	10	12
Three	4	2	3	2
Four or more	4	4	8	5
Not applic.	76	76	69	74
Total	100	100	100	100

TABLE 4.7 -- Frequency distributions of patient referrals,
as reported by type of provider

	PROVIDERS			
	DOC	HP	PHAR	TOTAL
N=	45	49	29	123
	%	%	%	%
Whether users reported OC problems needing referral (P422)				
Yes	16	31	38	27
No	84	69	62	73
Total	100	100	100	100
Types of problems (P423)				
Health (incl. hypertension, nausea, dizziness, mental illness)	7	14	17	12
Menstrual changes	9	10	17	11
Other	0	7	4	4
Not applic.	84	69	62	73
Total	100	100	100	100
Response of providers (P424)				
Referred to medical specialist	9	2	3	5
Referred to hospital	4	6	3	5
Referred to any doctor	0	8	30	11
Referred to family planning worker or clinic	0	12	3	6
Other	3	3	0	1
Not applic.	84	69	61	73
Total	100	100	100	100

TABLE 4.8 -- Frequency distributions of method switching
by responses of providers, users and husbands of users

	N=	PROVIDERS					USER	HUSB
		DOC	HP	PHAR	TOTAL			
	45	49	29	123	365	365		
	%	%	%	%	%	%	%	
Whether OC discontinuers switch to another method (P428, C437)								
Yes	64	59	79	56	6	10		
No	27	25	4	20	2	2		
Don't know/Not applic.	9	16	17	14	92	88		
Total	100	100	100	100	100	100		

Method usually switched to
(P429, C438)

Condom	33	39	62	42	4	7	
Spermicide	0	8	7	5	0	0	
IUD	24	2	7	11	1	1	
Other	7	6	3	6	1	2	
Don't know	0	4	0	2	0	0	
Total	100	100	100	100	100	100	

TABLE 4.9 -- Frequency distributions of users problems as reported by providers, users and husbands of users

	PROVIDERS				USER	HUSB
	DOC	HP	PHAR	TOTAL		
N=	45	49	29	123	365	365
	%	%	%	%	%	%
Whether providers have been asked about a problem (P403)						
Yes	73	71	72	72		
No	27	29	28	28		
Total	100	100	100	100		
<hr/>						
Type of problem (P404, C406)						
Vomiting	22	16	38	24	22	22
Dizziness	24	24	45	29	39	46
Weakness	2	20	28	15	12	22
Headache	13	10	7	11	0	0
Other health	13	14	17	15	27	42
Irregular or less menstruation	40	24	14	27	20	20
<hr/>						
Whether user has had and problems (C405)						
Yes					57	68
No					43	32
Total					100	100
<hr/>						
Action suggested by providers (P405); action taken by users (C407).						
Continue OCs	51	31	34	39	23	21
Switch method	0	0	0	10	0	1
Switch brand	11	6	0	7	3	4
Take medicine	9	20	7	13	11	14
Stop OCs	0	0	0	5	5	3
Consult doctor	0	0	0	17	8	10
Use special foods	0	0	0	0	4	11
Not applicable	27	29	28	28	43	32
Total	100	100	100	100	100	100

TABLE 4.9 (continued)

	PROVIDERS					
	DOC	HP	PHAR	TOTAL	USER	HUSB
N=	45	49	29	123	365	365
	%	%	%	%	%	%
Whether other types of problems reported (P406); Experienced (C408).						
Yes	42	30	17	31	9	15
No	58	70	83	69	48	51
Not applic.	0	0	0	0	43	34
Total	100	100	100	100	100	100
Type of problem (P407, C409)						
Health	22	6	10	13	6	12
Menstrual irreg.	4	14	0	7	1	1
Other	16	10	7	11	3	4
Not applic.	58	70	83	69	91	85

TABLE 4.10 -- Frequency distribution of users' perceptions of health changes

	DOC N = 45 %	USERS			ALL 123 %
		HP 49 %	PHAR 29 %		
Whether any changes noticed (C450)					
Yes	53	49	52	51	
No	47	51	48	49	
Total	100	100	100	100	
<hr/>					
Types of changes noticed (C451)					
Improved health	38	31	34	34	
Health problems (incl. weakness, dizziness, nausea)	17	12	17	15	
Menstrual changes	6	1	8	5	
Not applic.	47	51	48	49	
<hr/>					
Whether continued after noticing changes (C452)					
Continued	48	41	46	45	
Stopped	5	6	6	5	
Not applic.	47	53	48	50	
Total	100	100	100	100	
<hr/>					
Whether discussed changes/ problem with anyone (C453)					
Yes	26	22	36	27	
No	27	26	16	24	
Not applic.	47	52	48	49	
Total	100	100	100	100	

TABLE 4.10 (continued)

	USERS			
	DOC	HP	PHAR	ALL
N =	45	49	29	123
	%	%	%	%
Type of person (C454)				
Husband	10	12	25	15
Relative	7	4	7	6
Friend	5	5	5	5
Doctor	14	5	11	10
Family planning worker	5	5	5	5
Not applic.	72	78	64	72

TABLE 4.11 -- Frequency distributions of nausea and vomiting side-effects, as reported by providers, users and husbands of users

	PROVIDERS				USER	HUSB
	DOC	HP	PHAR	TOTAL		
N=	45	49	29	123	365	365
	%	%	%	%	%	%
Ever reported (P412); Ever occurred (C417)						
Yes	69	84	59	72	43	46
No	27	14	31	23	57	52
No response/ Don't know	4	2	10	5	0	2
Total	100	100	100	100	100	100

Providers advice (P413)						
Continue	55	55	31	50		
Use medicine	7	22	0	11		
Stop	0	10	7	6		
See doctor	2	4	20	7		
Not applic.	31	16	41	28		

Whether the couples believed problem caused by OCs (C421)						
Yes					45	43
No					2	2
Don't know					1	4
Not applic.					52	51
Total					100	100

Whether user quit (C418)						
Quit					3	6
Continued					39	40
Not applic.					58	54
Total					100	100

TABLE 4.11 (continued)

		PROVIDERS				
	DOC	HP	PHAR	TOTAL	USER	HUSB
N=	45	49	29	123	365	365
	%	%	%	%	%	%
Whether user took medicine (C419)						
Yes					19	19
No					24	26
Not applic.					57	54
Total					100	100
Whether the medicine helped (C420)						
Yes					17	18
No					2	1
Not applic.					81	81
Total					100	100
Whether a medicine would be acceptable to customers (P415)						
Yes	87	74	80	80		
No	9	8	7	8		
Not applic.	4	18	13	12		
Total	100	100	100	100		

TABLE 4.12 -- Frequency distributions of oligomenorrhea,
as reported by providers, users and husbands of users

	PROVIDERS					
	DOC N= 45 %	HP 49 %	PHAR 29 %	TOTAL 123 %	USER 365 %	HUSB 365 %
Ever reported (P416); Ever occurred (C422)						
Yes	69	78	79	75	44	44
No	13	12	21	15	55	51
No reponse/ Don't know	18	10	0	10	1	5
Total	100	100	100	100	100	100
<hr/>						
Providers advice (P4,7); Users' response (C423)						
Continue	40	45	52	45	42	41
Switch method	9	0	0	3	0	0
Switch brand	16	0	0	6	0	0
Give medicine	9	26	9	15	0	0
Stop pill	7	4	0	4	3	3
Go to doctor	5	8	24	11	0	0
Not applic.	31	21	21	24	55	56
Total	100	100	100	100	100	100

TABLE 4.13 -- Frequency distributions of forgetting and taking more than one pill daily

	PROVIDERS					
	DOC	HP	PHAR	TOTAL	USER	HUSB
N=	45	49	29	123	365	365
	%	%	%	%	%	%
Ever reported forgetting more than one pill (P401); Ever occurred (C414)						
Yes	78	76	66	74	17	12
No	22	24	34	26	83	81
Don't know	0	0	0	0	0	7
Total	100	100	100	100	100	100
<hr/>						
Whether happened often (P402, C415)						
Often	7	10	7	8	1	0
Not often	71	66	59	66	16	12
Not applic.	22	24	34	26	83	88
Total	100	100	100	100	100	100
<hr/>						
Users response (C416)						
Quit					2	2
Took 2					15	10
Not applic.					83	88
Total					100	100
<hr/>						
Whether ever taken more than one pill per day (C401)						
Yes					62	56
No					38	35
Don't know					0	9
Total					100	100
<hr/>						

TABLE 4.13 (continued)

	USER 365 %	HUSB 365 %
Whether occurred often (C402)		
Often	5	2
Not often	57	54
Not applic.	38	44
Total	100	100
<hr/>		
Reasons (C403)		
To catch up on forgetting pill	55	51
Other	7	5
Not applic.	38	44
Total	100	100
<hr/>		
Highest number ever taken on one day (C404)		
Two	53	51
Three	9	5
More than three	1	1
Not applic.	38	44
Total	100	100
<hr/>		

TABLE 5.1 -- Frequency distributions of attitude of users
and and husbands of users towards oral contraceptives

	USER	HUSB
N =	365	365
	%	
Attitude toward OCs (C502)		
Strongly favorable	83	67
Quite favorable	15	26
Neither favorable nor unfavorable	1	3
Quite unfavorable	0	2
Strongly unfavorable	1	2
Don't know	0	0
Total	100	100

Respondent's perception of spouse's attitude (C501)		
Strongly favorable	82	63
Quite favorable	13	32
Neither favorable nor unfavorable	4	1
Quite unfavorable	1	2
Strongly unfavorable	0	1
Don't know	0	1
Total	100	100

TABLE 5.2 -- Frequency distributions of percentages of breastfeeding, contraception and amenorrhea reported by users and husbands

	USER	HUSB
N =	365	365
	%	%
Perceived reason for postpartum amenorrhea (C503)		
Heavy bleeding at birth	7	12
Natural reasons	1	3
Breastfeeding	2	3
Other	1	3
Don't know	89	79
Total	100	100

Belief about risk of pregnancy during postpartum amenorrhea (C504)		
Yes	80	42
No	18	43
Don't know	2	15
Total	100	100

Whether conception is possible during breastfeeding (C505)		
Yes	91	76
No	4	14
Don't know	4	10
Total	100	100

Whether OCs affect breastfeeding (C506)		
Yes	63	43
No	27	37
Don't know	10	20
Total	100	100

TABLE 5.2 (continued)

	N =	USER 365 %	HUSB 365 %
Perceived effects of OCs on breastfeeding (C507)			
Can reduce/or dry up milk		62	43
Other		0	1
Not applic.		38	56
Total		100	100

Value of menstruation being stopped or diminished in quantity by a contraceptive injection or an OC (C516)			
Good		3	6
Neither good nor bad		14	20
Bad		78	67
Don't know		5	7
Total		100	100

Table 6.1 -- Selected Comparisons Between Past Users and Current Users

Question Number	Description	Characteristics of past users
C110	Education	Same
C6	Number of children	Same
C201	Usual obtainer	Same
C203	Usual provider	Same
C209	Difficulty of travel	Same
C210	Availability of supplies	Same
C312	Identify first pill	Husbands less accurate
C405	OC-related problems	More
C406H	Health side effects	More
C406M	Menstrual side effects	Same
C407	Response to side effects	Discontinued
C426	Duration of use	Shorter
C427	Dizziness/nausea as reason for discontinuing	More
C428	Start OCs again after discontinuing	No
C437	Use another method after discontinuing	Same
C441	Desire to use OCs in future	Much less
C442	Perceive OCs as injurious	More
C451	Deterioration in health	More
C454	Discuss health changes with husband	More
C502	Attitude toward OCs	Less favorable

Table 7.1 -- Selected characteristics of couples by usual type of provider

QUESTION NUMBER	DESCRIPTION	COMMENT
C108	Attended school	More Pharmacy customers. Fewer Family Planning Worker and clinic clients.
C110	Highest school level passed	Pharmacy customers higher than average.
C114	Husbands' occupation	Doctors and Pharmacy customers mostly service/government employees or businessmen. Health practitioner are mixed. Family Planning Workers mostly agriculturists.
C206	Usual obtainer	Husband goes to all three SMP providers. Wife obtains from the Family Planning Worker.
C217	Preferred brand	Pharmacy customers prefer Ovostat. Doctor and Health Practitioner customers prefer various brands.
C220	Household supplies overlap	Clients of Family Planning Workers and clinics tend to have additional supplies in house, but commercial sector customers do not.
C225	First provider	Same as usual provider. Dominated by pharmacists.
C301	Best instructor	User response: If obtained from Family Planning Worker she says the Family Planning Worker is the best instructor. If obtained from other sources she says husband is the best. Husbands' response: Doctors' are good.
C303	Interspouse communication	Better among clients of Health Practitioners.
C312	Identify first pill in the packet correctly.	Users: no differences. Husbands: Pharmacy customers better than Doctors or Health Practitioner.
C406	Health problems	Husbands' response: clients of Health Practitioners had fewer.

Table 7.2 -- Selected characteristics of couples by rural/urban residence

QUESTION NUMBER	DESCRIPTION	RURAL SAMPLE	
		URBAN %	RURAL %
C110	Education	Slightly more did not attend school.	
C114	Husband's occupation	More agriculturists. Only slightly fewer business/tradesmen.	
C215	Number of brands ever used	More women used only one brand.	
C214	Brand loyalty	More Maya and Noriday users had only used that one brand.	
C201	Usual obtainer	Same proportions.	
C225	First provider	URBAN %	RURAL %
		Doctors	15 6
		Health Practitioners	6 15
		Pharmacists	55 38
		Family Planning Workers/clinics	24 42
C203	Usual provider	URBAN %	RURAL %
		Doctors	11 4
		Health Practitioners	7 14
		Pharmacists	56 41
		Family Planning Workers/clinics	25 40
C209	Travel difficulties	More women and husbands.	
C220	Supplies overlap	More women have supplies on hand before they are needed.	
C301	Best instructor	Same proportion.	
C406	Has had health problems	Fewer women.	
C425	Continued without stopping	More women.	

APPENDIX B - QUESTIONNAIRE FOR PROVIDERS

HORMONAL CONTRACEPTIVES SURVEY-1984

Providers' Questionnaire.

FOR GRADUATE DOCTORS AND RHPS GO TO 104

FOR PHARMACIES SAY: I am from an independent research agency and I would like to talk with the person who usually talks to customers who need advice about medicines.

101. Are you the owner of this business or the manager ?

- 1 Owner
- 2 Manager
- 3 Other (Specify) _____

102. Is the current name of this pharmacy (READ NAME FROM LIST)?

- 1 Yes (Name) _____
- 2 No (Correct Name) _____
(Name of Town or Urban Area or Thana) _____

103. I would like to talk with you about certain types of medicine that you sell and the types of customers who buy them. But first I would like to know about yourself.

GO TO 105

104. I am from an independent research agency and I would like to talk with you about certain types of medicine you dispense or prescribe and the type of people who use them. But first, I would like to know about yourself. Is your correct name _____? (Interviewer: If
(READ FROM SAMPLE LIST)
the answer is No., obtain the correct name and write it in the appropriate space below)

- 1 Yes (Name) _____
- 2 No (Correct name) _____

105. Have you discussed Maya or Ovacon oral pills with an SMP representative ? Or have you purchased Maya or Ovacon pills ?

- 1 Yes (EITHER OR BOTH)
- 2 No (TERMINATE Q. ONLY AFTER PROBING).
GIVE REASON _____

106. What is your age ? (Specify) _____

- 1 Less than 20 years
- 2 20 to 29
- 3 30 to 39
- 4 40 to 49
- 5 50 and older

107. Are you married or have you ever been married ?

- 1 Married now
- 2 Never married
- 3 Have been married

108. What is your religion ?

- 1 Muslim
- 2 Hindu
- 3 Other (Specify) _____

109. What level of education have you completed ?

- 1 Primary
- 2 Madrasa
- 3 High school
- 4 College/University (Name of Degree _____)
- 5 Other (_____)

110. Would you say your main occupation is selling medicines ?
Or is your main occupation examining and advising sick
people ?
- 1 Selling medicines
 - 2 Examining and advising the sick
 - 3 Other
111. Is this place of business your full-time or part-time
place of business ?
- 1 Full-time
 - 2 Part-time (Specify other occupation) _____
112. For how many years have you been a doctor/pharmacist ?
(VERBATIM) _____ years.
113. Do you usually provide medicine yourself directly to a
patient/customer or does someone else in this place of
business do that, or is medicine not available here ?
- 1 I usually provide medicine directly, myself
GO TO 115
 - 2 Someone else usually does it
 - 3 Medicine is not available here GO TO 118
114. Do you oversee the provision of medicine yourself or does
someone else oversee the provision of medicine ?
- 1 I oversee it myself
 - 2 Someone else
115. Are injections stocked here ?
- 1 Yes
 - 2 No GO TO 118

116. Do you yourself inject medicine ?

- 1 Yes
- 2 No GO TO 118

117. Which of the injections you stock are used most often ?
(List upto 3)

- 1 _____
- 2 _____ GO TO 119
- 3 _____

118. If a person needs an injection, to whom do you send him ?
(PROBE)

- 1 Name _____
- 2 Type of doctor _____
- 3 Address _____

119. Which person do you treat most often: men, women or children ?

- 1 Men
- 2 Women
- 3 Children

120. Which person do you treat least often ?

- 1 Men
- 2 Women
- 3 Children

121. If a woman needs your help, does she usually come to you herself, or does she send someone else ?

- 1 Usually comes to me herself GO TO 123
- 2 Usually sends someone else

122. If a woman does not come to you herself, who does she usually send to talk to you ?

(VERBATIM) _____

123. Have you ever felt that treatment of a particular health problem was beyond your capability ?

1 Yes

2 No GO TO 201

124. What would you do, when this occurs ? (PROBE) (IF PATIENT IS REFERRED TO ANOTHER DOCTOR, SPECIFY)

1 Does not refer patient to another doctor

2 Refers patient to another doctor

Name _____

Type of doctor _____

Address _____

3 Other _____

8 Don't know

SECTION-2: RETAIL PATTERNS

Now I would like to ask you about the oral contraceptive pills that you provide.

201. What are the names of the pills that you usually stock ?

- 1 _____
- 2 _____
- 3 _____
- 4 _____
- 9 Don't stock oral pills GO TO 203

202. So you stock a total of _____ brands of pills. Is that correct ?

CHECK THAT Q. 201 AND 202 AGREE.

203. Which brand do you provide most often ? _____

204. Why do you provide that brand most often ? (PROBE)

- 1 _____
- 2 _____
- 3 _____

205. Is there another reason as well ?

- 1 Yes (PROBE AND SPECIFY) _____
- 2 No

206. About how many packets of pills have you sold/prescribed in the last four weeks ?

- 207a. Do some of your customers/Clients obtain more than one packet of pills at a time.
- 1 Yes
 - 2 No Go To 209
 - 8 Don't know Go To 209
- 207b. How many packets does a customer/client usually obtain at one time.
- 1 One
 - 2 Two
 - 3 Three or more
208. In the case where a customer/client obtains more than one packet of oral pills, would you say he is obtaining them all for the same woman to use or for more than one woman to use ?
- 1 The same woman
 - 2 Different woman
 - 8 Don't know
209. Some people think that when a couple first start on the pill they should buy two packs so they will then probably continue correctly from the end of the first pack to the start of the second pack. Do you think this is a good idea ?
- 1 Yes
 - 2 No
 - 8 Don't know
210. Do you think that most couples, when buying their first supply would be willing or unwilling to purchase two packets instead of one ?
- 1 Willing
 - 2 Unwilling
 - 8 Don't know

211. Who usually purchase the pills from you: the user hereself or someone else ?

- 1 User herself
- 2 Some else (Specify relationship) _____
- 8 Don't know

212. In your opinion, if a couple is satisfied with pills and wish to continue using them, where would they usually go to buy more: to you, to your assistant, or some other place ?

- 1 To me, myself
- 2 To my assistant or somebody else in this palce of business
- 3 Other place
- 8 Don't know

213. How many months have you stocked SMP Maya Ovacon ?

_____ months.



SECTION-3: PROVIDERS' RELATIONSHIP WITH COUPLES

301. In your experience do most people who want to begin practising FP know which method they wish to use before they come to you or do they usually ask your advice ?
- 1 They usually know GO TO 303
 - 2 They ask
 - 8 Don't know
302. Has anyone ever asked you which method you would suggest ?
- 1 Yes
 - 2 No GO TO 304
 - 8 Don't know GO TO 304
303. And which method do you usually suggest ?
- 1 Pill
 - 2 Condom
 - 3 Sterilization
 - 4 IUD
 - 5 Other (Specify) _____
304. Now I would like to discuss oral contraceptive pills. How does a person become aware that you can provide them with oral pills ? Does their first knowledge that you have oral pills usually come from you, directly, or from some other source ?
- 1 Directly from me, myself
 - 2 Some other source
 - 8 Don't know
305. When you first discuss oral pills with a potential client couple who do you usually discuss with first, the wife or the husband ?
- 1 The wife
 - 2 The husband
 - 3 Someone else (Specify) _____

306. And what do you tell them about how to take the pills ?
In the case where the couple has not used pills before
and so you are providing them for the first time do you
usually say on what day the woman should take the first
pill from the first packet ?
- 1 Yes
 - 2 No GO TO 308
307. And what exactly do you tell about when to take that
first pill ?
- (VERBATIM) _____ GO TO 309
308. When do you think a woman should take the first pill ?
- (PROBE) _____
309. And do you usually tell them which pill in the package they
should take first ? I mean do you tell them that the first
time you are providing them with oral pills ?
- 1 Yes
 - 2 No GO TO 312
310. Do you actually tell them or do you show them ?
- 1 Tell
 - 2 Show GO TO 312
311. Exactly what do you tell them about which pill in the
package should be taken first ?
- (VERBATIM) _____
312. Which pill in the package should a woman take first ?
Please show me from this package (OFFER HIM PACKS OF
MAYA AND OVACON).
- 1 Correctly shown
 - 2 Pointed on the wrong pill
 - 3 Refused
 - 8 Don't know

313. And do you usually instruct them on when to continue with the second pill and the third, and so on ? I mean do you tell them that the first time you are providing them with oral pills.
- 1 Yes
 - 2 No GO TO 315
314. Exactly what do you tell them ?
- (VERBATIM) _____ GO TO 316
315. When should a woman take the second pill, the third, etc. ?
- (PROBE) _____
316. Do you usually instruct them on what time of day the pill should be taken ? I mean do you tell them that the first time you are providing them with oral pills.
- 1 Yes
 - 2 No GO TO 318
317. Exactly what do you tell them about what time of day the pill should be taken ?
- (VERBATIM) _____
318. Do you think it is important or not important that the woman takes the pill at the same time every day ?
- 1 Important
 - 2 Not important
 - 8 Don't know
319. And do you usually tell what to do when the woman finishes the first package ? I mean do you usually say when she should begin on the second package ? I mean do you tell them that the first time you are providing them with oral pill .
- 1 Yes
 - 2 No GO TO 321

320. And exactly what do you say about when the woman should begin the second pack ?

(VERBATIM) _____ GO TO 322

321. When should the woman begin the second pack ?

(PROBE) _____

8 Don't know

322. Are there any other instructions that you usually give to a person when the woman is going to be using oral pills for the first time ?

1 Yes

2 No GO TO 324

8 Can't remember GO TO 324

323. Please tell me those instructions.

1 _____
2 _____
3 _____

324. IF "FORGETTING TO TAKE PILL" NOT MENTIONED IN 323, SAY :
Sometimes a woman might forget to take a pill. Do you usually instructs a new pill purchaser about this topic ?

1 Yes

2 No GO TO 326

8 Can't recall GO TO 326

325. Exactly what do you say about what to do if the woman forgets to take one pill ?

(VERBATIM) _____ GO TO 327

326. What do you think a woman should do if she forgets to take a pill ?
- (PROBE) _____
- 8 Don't know
327. Sometimes a couple has had a baby and wants to use oral pills to prevent having another too soon. Have you ever discussed that ? I mean discussed how long the woman should wait after the baby is born before she begins taking the pill.
- 1 Yes
- 2 No GO TO 329
- 3 Don't recall GO TO 329
328. And what do you tell that person about how long after childbirth the woman should wait before beginning pills ?
- (VERBATIM) _____ GO TO 330
329. What do you believe about that ? I mean how long do you think a woman should wait after childbirth before beginning the pill ?
- (VERBATIM) _____
- 8 Don't know
330. When advising a first purchaser of oral pills do you tell the person about possible effects the pill might have on a woman other than preventing pregnancy ?
- 1 Yes
- 2 No GO TO 401
331. What other effects do you usually tell them about at that time (PROBE) ?
- 1 Anything else ? _____
- 2 Anything else ? _____
- 3 Anything else ? _____

SECTION-4: USER PROBLEMS

Now I would like your opinion about problems of oral pill taking among your clients/customers.

401. Has anyone ever come to you and said that more than one pill was forgotten, and not taken ?

- 1 Yes
- 2 No GO TO 403
- 8 Don't know GO TO 403

402. Would you say this had happened often, or not very often ?

- 1 Often
- 2 Not very often

403. Has anyone come to you and asked about another problem that the woman may be having with pill taking ?

- 1 Yes
- 2 No GO TO 412
- 8 Don't know GO TO 412

404. What kind of a problem was that ?

(VERBATIM) _____

405. And what did you tell them ?

(VERBATIM) _____

406. Have you ever had another type of problem reported to you ?

- 1 Yes
- 2 No GO TO 412
- 8 Don't know GO TO 412

407. And what was that problem ?

(VERBATIM) _____

408. And what did you tell them ?

(VERBATIM) _____

409. Any other problem reported to you ?

- 1 Yes
- 2 No GO TO 412
- 8 Don't know GO TO 412

410. And what was that problem ?

(VERBATIM) _____

411. And what did you reply ?

(VERBATIM) _____

412. IF "DIZZINESS/GIDDINESS/STOMACH UPSET/NAUSEA" NOT REPORTED AS A PROBLEM, SAY: Some women report dizziness/giddiness/stomach upset/nausea after taking oral pills. Has that problem ever been reported to you ?

- 1 Yes
- 2 No GO TO 414
- 8 Don't know GO TO 414

413. What was your response ?

(VERBATIM) _____ GO TO 415

414. If that kind of problem were reported to you what would your response be ?

(VERBATIM) _____

415. IF " GIVE ANOTHER MEDICINE TO STOP THE PROBLEM WHILE CONTINUING WITH PILL" NOT MENTIONED ASK: If another medicine were available at an affordable price which she could take to stop the problem while continuing with the oral pill, do you think it would be acceptable by your customers/clients ?

- 1 Yes
- 2 No
- 8 Don't know

416. IF "SCANTY MENSTRUAL BLEEDING" OR "NO MENSTRUAL BLEEDING" WAS NOT REPORTED (S A PROBLEM, SAY: Some women report scanty menstrual bleeding or no menstrual bleeding when taking oral pill. Has that problem ever been reported to you ?

- 1 Yes
- 2 No GO TO 418
- 8 Don't know GO TO 418

417. What was your response ?

(VERBATIM) _____ GO TO 419

418. If that kind of problem were reported to you what would your response be ?

(VERBATIM) _____

419. Do you think any women can take pills safely ? or do you think some women should never take oral pills ?

- 1 Any women can take pills safely GO TO 421
- 2 Some women should never take pills

420. What women should not take ? (PROBE)

- 1 _____
- 2 _____
- 3 _____
- 4 _____

421. Some of the women who use pills may be breastfeeding their baby. Do you feel that the pill might cause some problem for breastfeeding mothers or not

- 1 The pill can cause problems for breastfeeding mothers
- 2 The pill does not cause problems for breastfeeding mother
- 8 Don't know

(WRITE ADDITIONAL COMMENTS IF OFFERED) _____

422. Have any of your pill users reported any pill-related problems which you thought were important enough to be referred to some one else ?

- 1 Yes
- 2 No GO TO 425
- 8 Don't know GO TO 425

423. What type of problem was that (Specify) _____

424. What did you recommend to the patient ? _____

425. Many women take family planning pills for some time and then stop. There can be many possible reasons for this. What, in your experience, are the most important reasons for women stopping taking the pill ? (PROBE)

- 1 _____
- 2 _____
- 3 _____

426. Although the pill is very effective for preventing pregnancy some women do become pregnant while taking the pill. Have any of your users become pregnant while using the pill?

- 1 Yes
- 2 No GO TO 428
- 8 Don't know GO TO 428

427. How many ? _____

428. For those women who stop taking oral pills but are not pregnant, do you think most women switch to another method or not ?

- 1 Switch
- 2 Don't switch GO TO 501
- 8 Don't know GO TO 501

429. What method do they usually switch to ?

(VERBATIM) _____
8 Don't know GO TO 501

430. Any other methods you have heard that they have switched to ?

- 1 _____
- 2 _____

SECTION-5: ATTITUDES ABOUT CONTRACEPTIVES

501. Have you heard of the family planning injection for women ?
- 1 Yes
 - 2 No
 - 8 Don't know
502. If a contraceptive injection were available, do you think that people in your care would want to use it ?
- 1 Yes
 - 2 No
 - 8 Don't know
503. If it were available would you stock it and provide it to your clients ?
- 1 Yes
 - 2 No GO TO 505
 - 8 Don't know GO TO 505
504. Would you suggest to your clients already using pills that they should switch to the injection or would you prefer that the pill users should continue using the pill ?
- 1 I would suggest that they switch to the injection
 - 2 I would prefer that they continue using the pill
 - 8 Don't know
505. Which type of injection do you think would be best: one that should be given every month or one that should be given every two months ? or every three months ?
- 1 Injected every month
 - 2 Injected every two months
 - 3 Injected every three months
 - 8 Don't know

506. What do you think is an affordable price that most people of your area will be willing to pay for a contraceptive injection that would protect the woman for _____

(Number of months in 505)

Taka: _____

507. The contraceptive injection often causes temporary amenorrhea. If a woman is told about this before having the injection, do you think she would still want to have the injection or would she prefer some other contraceptive method that does not interfere with menstruation ?

- 1 She would probably want to use the injection.
- 2 She would probably not want to use
- 8 Don't know

508. A very few women have reported very heavy menstrual bleeding after using the injectable contraceptive. If a woman is told this before having the first injection, do you think she would still want to have the injection or would she prefer some other contraceptive method that may not cause this very heavy menstruation ?

- 1 She would probably want to use injection
- 2 She would probably not want to use injection
- 8 Don't know

509. What would your recommendation be for a woman who reported very heavy menstrual bleeding ?

(VERBATIM) _____

- 8 Don't know GRADUATES GO TO 701
PHARMACISTS GO TO 801

510. Is that service you have just suggested available ?

- 1 Yes
- 2 No GRADUATES GO TO 701, PHARMACISTS GO TO 801
- 8 Don't know GRADUATES GO TO 701, PHARMACISTS GO TO 801

511. About how long would it take one of your patients/
customers to get to that service ?

(VERBATIM) _____

GRADUATE DOCTORS GO TO 701

PHARMACISTS GO TO 801

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SECTION-6: (FOR RURAL HEALTH PRACTITIONERS ONLY) RELATIONSHIP
WITH MBBS DOCTORS

601. Are you aware of graduate (MBBS) doctors in this area ?

- 1 Yes
- 2 No GO TO 605

602. How many do you know the names of ?

- 1 One
- 2 Two
- 3 Three
- 4 Four
- 5 Five or more

603. Have you worked with any of those doctors in any way ?

- 1 Yes
- 2 No GO TO 605

604. In what ways ? (Specify)

- 1 _____

- 2 _____

- 3 _____

605. If, in the future, one of your patients/clients should become quite ill, let's say, had a serious reaction to some medicine you had given, and you had no way of treating the problem yourself, what would you probably do ? (PROBE)
- 1 Suggest that the patient should go to a hospital
 - 2 Suggest that the patient should go to another doctor
 - 3 Other (Specify) _____

 - 4 Do nothing
 - 8 Don't know
606. How did you learn your medical knowledge ? Did you attend a training course ? Or did you learn from another person on-the-job ? Or did you learn completely by yourself ?
- 1 Training course (Specify) _____
 - 2 From another person
 - 3 By self
 - 4 Other(Specify) _____
607. How often would you say you take oral pills to the home of a user ? Would you say very often, quite often, not very often, rarely, never ?
- 1 Very often
 - 2 Quite often
 - 3 Not very often
 - 4 Rarely
 - 5 Never

SECTION-7: (FOR GRADUATE DOCTORS ONLY) RELATIONSHIP WITH
RURAL HEALTH PRACTITIONERS

701. Are you aware of rural health practitioners (unqualified) village doctors or "quacks" who practice medicine using western or allopathic medicine in your area ?

- 1 Yes
- 2 No GO TO 705

702. Approximately how many do you know the names of in your area? (SPECIFY THE TOTAL NUMBER _____)

703. Do you work with any of those rural health practitioners in any way ?

- 1 Yes
- 2 No GO TO 705

704. In what ways ? (Specify)

- 1 _____
- 2 _____
- 3 _____

705. Do you think that most of the rural health practitioners give injections of any type ?

- 1 Yes
- 2 No
- 8 Don't know

706. If injectable contraceptive (or intramuscular injection were available, do you think the rural health practitioners could be trained to give the injections successfully in their villages ?

- 1 Yes
- 2 No GO TC 709
- 3 Don't know GO TO 709

707. What specific kinds of training would they need ?
(Specify)

- 1 _____
- 2 _____
- 3 _____
- 4 _____
- 5 Don't know

708. Suppose they did give contraceptive injections and a patient developed a serious reaction or complication. What do you think the rural health practitioner might do (PROBE) ?

- 1 Suggest she go to a hospital
- 2 Suggest she go to a graduate doctor such as yourself
- 3 Other (Specify) _____
- 4 Continue to attempt treatment himself
- 5 Nothing
- 6 Don't know

709. Suppose a family planning scheme was started using injectable contraceptives. What role do you think rural health practitioners might play? (PROBE).
MULTIPLE RESPONSES POSSIBLE.

- 1 Refer eligible women to a provider of injectable contraceptives
- 2 Gather village women together for a visit by a graduate doctor who would inject the contraceptive
- 3 Provide follow-up care and reminders to women who had received injections
- 4 Other (Specify) _____

- 5 None
- 8 Don't know

710. Where do you see most of your patients?

- 1 In chamber of your own
- 2 In a chemist/pharmacy shop
- 3 Other (Specify) _____

GO TO 901

SECTION-8: (FOR PHARMACISTS ONLY) RELATIONSHIP WITH DOCTORS

801. Are you aware of graduate doctors in this area ?

- 1 Yes
- 2 No GO TO 805

802. How many do you know the names of ?

- 1 One
- 2 Two
- 3 Three
- 4 Four
- 5 FIVE or more

803. Have you worked with any of those doctors in any way ?

- 1 Yes
- 2 No GO TO 805

804. In what ways ? (.Specify)

- 1 _____
- 2 _____
- 3 _____

805. IF NOT MENTIONED IN 804

ASK: Does a graduate doctor work in this place of business ?
I mean either full-time or part time ?

- 1 Yes
- 2 No GO TO 807

806. Full-time or part-time ?

- 1 Full-time
- 2 Part-time

807. How did you learn your medical knowledge ? Did you attend a training course ? Or did you learn from another person on-the-job ? Or did you learn completely by yourself ?

- 1 Training course (Specify) _____
- 2 From another
- 3 By self
- 4 Other (Specify) _____

SECTION-9:

901. Do you think that all of the couples you have ever provided with oral pills are still using or do you think some have stopped using ?

- 1 All are using GO TO 903
- 2 Some have stopped
- 3 Don't know GO TO 904

902. Please give me the names and addresses of those people who you know take stopped using oral pills ?

- 1 _____
- 2 _____
- 3 _____
- 4 _____
- 5 _____

903. Please give me the names of those people you know are still using oral pills ?

- 1 _____
- 2 _____
- 3 _____
- 4 _____
- 5 _____

904..- THANK You very much for your assistance.

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APPENDIX C - QUESTIONNAIRE FOR COUPLES

Couple Questionnaire

FOR EITHER HUSBAND OR WIFE---WHICHEVER IS CONTACTED FIRST:

Respondent:

HUSBAND

WIFE

ID No. of Respondent _____

We are conducting a research in family welfare and family planning. For this research I need to ask you some questions. I hope you would not mind answering the questions. Whatever you say will be kept confidential. It will be used only for the research.

A. Are you married ?

1 Yes.

2 No. TERMINATE INTERVIEW.

B. Do you live with your husband/wife ?

1 Yes.

2 No. TERMINATE INTERVIEW.

C. Is he/she available now ?

1 Yes. ASK TO INTERVIEW HIM/HER. GO TO 101

2 No.

D. When will he/she be available so that we can talk with you both at the same time.

ARRANGE SUITABLE TIME FOR CALL-BACK

INTERVIEW HUSBAND AND WIFE SEPARATELY. ASK:

SECTION 1. BACKGROUND/CHARACTERISTICS OF RESPONDENTS

101. How long have you and your husband/wife been married ?
(Number of years) _____

102. Have you or your husband used any method of preventing pregnancy. I mean any family planning method ?

- 1 Yes.
- 2 No. GO TO 104

103. Which method have you used ?
VERBATIM _____

INTERVIEWER: TICK APPROPRIATE BOX Used pill Not used pill

GO TO 106

104. Have you heard of the family planning pill that some women take to prevent pregnancy ? PROBE.

- 1 Yes.
- 2 No.

105. Have you/your wife ever used that family planning pill ?

- 1 Yes.
- 2 No.

TERMINATE INTERVIEW ONLY IF SURE THAT RESPONDENT HAS NO KNOWLEDGE OR USE OF PILLS. WRITE CLEARLY YOUR COMMENTS AND OBSERVATIONS BELOW.

Interview Result:

- 1 Completed.
- 2 Reportedly never knew or used pill
- 3 Deferred.
- 4 Refused.
- 5 Other. _____

Handwritten mark

106. How old were you when you and your husband/wife were married ?

AGE IN COMPLETED YEARS _____

107. And how old are you now ?

AGE IN COMPLETED YEARS _____

ANSWER TO 101 _____

ANSWER TO 106 _____

TOTAL _____

COMPARE WITH ANSWER TO 107 IF TOTALS DO NOT AGREE
PROBE AND OBTAIN CORRECT ANSWERS.

108. Did you ever attend school ?

- 1 Yes
- 2 No GO TO 111

109. Was it a primary school, madrasa, secondary school or higher that you attended last ?

- | | | | |
|------------------------|----------------------|-------------|---|
| Primary | 1 | High school | 2 |
| College/
University | 3 | Madrasa | 4 |
| 5 | Other(SPECIFY) _____ | | |

110. What was the highest class you passed at that level ?

(SPECIFY) _____

111. What is your religion ?

- 1 Islam
- 2 Hinduism
- 3 Christianity
- 4 Buddhism
- 5 Other(SPECIFY) _____

FOR HUSBANDS: GO TO 114

112. Aside from doing normal housework do you do any other work (for cash or kind) on a regular basis such as agricultural work, making things for sale, selling things in the market, or anything else.

- 1 Yes
- 2 No GO TO 115

113. Did you earn any money from this work during the last year ?

- 1 Yes
- 2 No
GO TO 115

114. What is your occupation ?

(SPECIFY) _____

115. Does your family own any agricultural ?

- 1 Yes _____
(quantity)
- 2 No
- 8 Don't know

116. Do you have a television in the household ?

- 1 Yes
- 2 No

117. Do you ever watch television yourself ?

- 1 Yes
- 2 No

118. Do you have a radio in the household ?

- 1 Yes
- 2 No

119. Do you ever listen to radio yourself ?

- 1 Yes
- 2 No

SECTION 2. ORAL CONTRACEPTIVE BUYING PATTERNS

201. Who usually obtains/obtained pills for you (your wife) ?

- 1 Self GO TO 203
- 2 Spouse
- 3 Other _____
(Specify)

202. Do you know where from your spouse (husband/wife/
Other _____) usually obtains/obtained the pill.

- 1 Knows
- 2 Does not know GO TO 206

203. Please tell me the name of the place/person from where or
whom your pills are/were usually obtained ? (Specify the
category mentioned by writing the name against the category)

- Doctor _____
- Quack _____
- Pharmacy _____
- Other _____

204. In addition to the source you have mentioned, have you/has
your spouse ever procured pills from any other sources ?

- 1 Yes
- 2 No GO TO 206
- 3 Don't know GO TO 206

205. Please tell me the names of those additional sources ?

206. Do you (does your spouse/other _____) usually go to buy the pills or are/were the pills usually brought home by someone else ?
- 1 I/we usually go
 - 2 Pills usually brought to home by someone else (Specify) _____) GO TO 210
 - 8 Don't know
207. How do you/does your spouse/other _____) travel to obtain the oral pill: by walking or by riding ?
- 1 Walking
 - 2 Riding
 - 8 Don't know
208. If you were to travel to that place, about how much time would it take to get there from here ?
- 1 Less than 10 minutes
 - 2 10 minutes - 19 minutes
 - 3 20 minutes - 29 minutes
 - 4 30 minutes - Less than 1 hour
 - 5 1 hour - Less than 2 hours
 - 6 2 hours or more
 - 8 Don't know
209. Do you think this place is difficult or not difficult to get to ?
- 1 Difficult
 - 2 Not difficult
 - 8 Don't know

210. Have the pills always been available when you want them or are they sometimes unavailable ?

- 1 Always available GO TO 212
- 2 Sometimes unavailable
- 8 Don't know GO TO 212

211. Why are they sometimes unavailable ? PROCBE

- 1 _____
- 2 _____
- 8 Don't know.

212. How do you think it would be possible to improve the availability of the pills.

- 1 (SPECIFY) _____
- 2 (SPECIFY) _____

213. Is the brand of oral pills you/your wife use/s always the same brand, or is it sometimes a different brand ?

- 1 Same.
- 2 Different. GO TO 215
- 8 Don't know. GO TO 218

214. What brand is that. What is the name of that package ?

- (SPECIFY) _____ GO TO 218
- 8 Don't know.

215. How many different brands have you/your wife had ?

- 1 Two.
- 2 More than two.
- 8 Don't know. GO TO 217

222. Some people think that when a couple first start on the pill they should buy two packs so they will then probably continue correctly from the end of the first pack to the start of the second pack. Do you think this is a good idea ?
- 1 Yes
 - 2 No
 - 8 Don't know
223. Do you think that most couples, when buying their first supply would be willing or unwilling to purchase two packets instead of one ?
- 1 Willing
 - 2 Unwilling
 - 8 Don't know
224. And later ? I mean suppose a couple used the pill and wanted to continue to use it. Then, do you think they would be willing or unwilling to purchase two packets instead of one ?
- 1 Willing
 - 2 Unwilling
 - 8 Don't know
225. From which kind of person did you obtain your very first packet of pills: Graduate doctor, Quack, Chemist, Family Planning Workers or other person ?
- 1 Graduate doctor
 - 2 Quack
 - 3 Chemist
 - 4 Family Planning Worker
 - 5 Other _____
 - 8 Don't know

226. Compare 225 and 203. IF NOT THE SAME ASK: You said
the oral pills were first obtained from Answer given in 225
but that you usually have obtained them from Answer
given in 203, Why is that? I mean why were the oral
pills usually obtained from Answer in 203 and not from
Answer in 225

SECTION-3: INSTRUCTIONS RECEIVED

301. Which person has taught you/your wife the most about how and when you/she should take the oral pills ?
- _____.
302. And who else ? Is there another person who has instructed you/your wife on oral pill taking ?
- 1 Yes (SPECIFY) _____
- 2 No
- 8 Don't know
303. How much would you say that you and your husband/wife talked about using the oral pill before they were obtained from SEE 225 ANSWER. Would you say you both discussed it very much, quite a lot, not so much, only a little or not at all.
- 1 Very much
- 2 Quite a lot
- 3 Not so much
- 4 Only a little
- 5 Not at all
304. Now I would like to ask you about the instructions you/she received the very first time the oral pills were obtained from (SEE 225 ANSWER). Did that person instruct you/your wife himself/herself, or did someone else instruct you/your wife.
- 1 The provider in 225 instructed me/her, directly. GO TO 306
- 2 Another person
- 8 Don't know GO TO 306
305. Who was that person ? Who instructed you/your wife about how and when you/she should take oral pills ? I mean at the time you/she first obtained them ?
- _____

306. Now I would like to know what instructions you/she received at the time the oral pills were obtained. Were you/was she instructed on what day you/she should take the first pill from the first packet ?
- 1 Yes
 - 2 No
 - 8 Don't know/can't recall
307. And exactly what were you/your wife told about when to take the first pill from the first packet ?
- _____
308. When do you think a woman should take the first pill ? On what day ? (PROBE) _____
309. And were you/your wife told which pill in the package a woman should take first ?
- 1 Yes
 - 2 No GO TO 312
310. Were you/your wife actually told or were you shown ?
- 1 Told
 - 2 Shown GO TO 312
311. Exactly what were you/your wife told about which pill in the package should be taken first ? VERBATIM _____
- _____
312. Which pill in the package should a woman take first ? Please show me from this package (OFFER CHOICE OF MAYA AND OVACOM AND OVOSTAT)
- 1 Correctly shown
 - 2 Pointed on the wrong pill
 - 3 Refused
 - 8 Don't know

313. And were you/your wife told when to continue with the second pill and the third, and so on ?
- 1 Yes
 - 2 No GO TO 315
314. Exactly what were you/your wife told ?
- VERBATIM _____ GO TO 316
315. When should a woman take the second pill, the third etc. ? (PROBE) _____
316. Were you/your wife told what time of day the pill should be taken ?
- 1 Yes
 - 2 No GO TO 318
 - 8 Don't know/Don't recall. GO TO 318
317. Exactly what were you/your wife told about what time of day the pill should be taken ?
- VERBATIM _____
318. Do you think it is important or not important that the woman takes the pill at the same time every day ?
- 1 Important
 - 2 Not important
 - 8 Don't know
319. And were you/your wife told what to do when a woman finishes the first package ? I mean were you told when she should begin on the second package ?
- 1 Yes
 - 2 No GO TO 321

320. And exactly what were you/your wife told about when the woman should begin the second pack ?

VERBATIM _____ GO TO 322

321. When should the woman begin the second pack ? (PROBE)

8 Don't know.

322. Were there any other instructions that you/your wife received at the time the first pack was obtained ?

1 Yes

2 No GO TO 324

8 Can't recall/don't know GO TO 324

323. Please tell me those instructions..

1 _____

2 _____

3 _____

324. IF "FORGETTING TO TAKE THE PILL" NOT MENTIONED IN 323, SAY:
Sometimes a woman might forget to take a pill. Have you/
your wife been told what the woman should do if she forgets
to take one pill ?

1 Yes

2 No GO TO 327

8 Can't remember. GO TO 327

325. When were you/your wife told about this ? Did you learn of it before you/your wife began taking pills for the first time, or at a later time ?

- 1 Before starting taking pills
- 2 Later
- 3 Can't recall

326. Exactly what were you/your wife told to do if you/your wife should forget to take one pill ?

VERBATIM _____ GO TO 328

327. What do you think you/your wife should do if you/she should forget to take one pill ?

PROBE _____

328. Have you been told about possible effects the pill might have on a woman other than preventing pregnancy ?

- 1 Yes
- 2 No GO TO 331
- 3 Don't know/can't recall GO TO 331

329. What effects have you been told about ? PROBE

- 1 _____
- 2 Anything else _____
- 3 Anything else _____
- 4 Anything else _____

330. When were you/was your wife told about this ? Before you/she began taking oral pills for the first time or at a later time ?
- 1 Before
 - 2 Later
 - 8 Don't know
331. IF "DIZZINESS/GIDDINESS/STOMACH UPSET/NAUSEA" NOT MENTIONED IN 329 ASK: Before you/your wife first began taking oral pills, were you/was she told that the pills might make a woman dizzy or upset the stomach ?
- 1 Yes
 - 2 No GO TO 333
 - 8 Don't know GO TO 333
332. And what were the instructions ?
-
333. IF "SCANTY MENSTRUAL BLEEDING OR NO MENSTRUAL BLEEDING" NOT MENTIONED IN 329 ASK: Before you/your wife first began taking oral pills, were you/was she told that the pills might reduce the amount of menstrual bleeding ?
- 1 Yes
 - 2 No GO TO 335
 - 8 Don't know GO TO 335
334. And what were the instructions ?
-

335. Sometimes a couple has had a baby and wants to use oral pills to prevent having another too soon. Have you/your wife told about that? I mean told how long the woman should wait after the baby is born before she begins taking the pill?
- 1 Yes
 - 2 No GO TO 337
 - 8 Don't know/can't recall GO TO 337
336. And what have you/your wife been told about how long after childbirth the woman should wait before beginning oral pills?
- VERBATIM _____ GO TO 338
337. What do you believe about that? I mean how long do you think a woman should wait after childbirth before beginning the oral pill?
- VERBATIM _____
338. Since beginning to take the oral pill, have you/your wife ever had a question about the pill that you wanted answered?
- 1 Yes
 - 2 No GO TO 342
 - 8 Don't know/can't recall GO TO 342
339. Did you and your husband/wife discuss the problem with each other?
- 1 Yes
 - 2 No
 - 8 Don't recall
340. Did you discuss the problem with anyone else?
- 1 Yes
 - 2 No GO TO 342
 - 8 Can't recall GO TO 342

341. With whom ? _____

342. If you/your wife should have a question about the pill in the future, do you think you would discuss it with each other or not ?

- 1 Would discuss it
- 2 Would not discuss it
- 8 Don't know

343. Who else would you/she probably discuss it with ?

SECTION 4. USER PRACTICES AND PROBLEMS

401. Have you/has your wife ever taken more than one pill on one day ?

- 1 Yes.
- 2 No. GO TO 405
- 8 Don't know. GO TO 405

402. Would you say this has happened often or not often ?

- 1 Often.
- 2 Not often.
- 8 Don't know.

403. Why did you/she take more than one pill on one day ?

PROBE _____

404. What is the highest number of pills you/she has ever taken on one day ?

- 1 Two.
- 2 Three.
- 3 More than three (SPECIFY NUMBER) _____

405. Have you/your wife ever had any problems with taking oral pills ?

- 1 Yes.
- 2 No. GO TO 414
- 8 Don't know. GO TO 414

406. What kind of problem ?

VERBATIM _____

407. And what did you do about this problem ?

408. Did you/your wife ever have another type of problem ?

- 1 Yes.
- 2 No. GO TO 414
- 8 Don't know. GO TO 414

409. What kind of problem ?

VERBATIM _____

410. And what did you do about this problem ?

VERBATIM _____

411. Any other problem ?

- 1 Yes.
- 2 No. GO TO 414
- 8 Don't know. GO TO 414

412. What kind of problem ?

VERBATIM _____

413. And what did you do about this problem ?

VERBATIM _____

414. IF "FORGOT TO TAKE/DID NOT TAKE PILLS" NOT MENTIONED AS PROBLEM, ASK: Have you/Has your wife ever forgotten to take an oral pill for two days/more in a row. I mean forgotten to take a pill on one day and also the next day, and perhaps even longer ?

- 1 Yes.
- 2 No. GO TO 417
- 8 Don't know. GO TO 417

415. Would you say this has happened very often or not very often ?

- 1 Has happened often.
- 2 Has not happened often.
- 8 Don't know.

416. And what did you/your wife do about the problem ?
Did you/your wife stop taking pills altogether, or
start taking one a day when you/she remembered, or
take more than one to catch up ?
- 1 Stopped altogether.
 - 2 Started again when remembered.
 - 3 Took more than one to catch up.
 - 4 Other _____
 - 8 Don't know.
417. IF "DIZZINESS/GIDDINESS/STOMACH UPSET/NAUSEA" NOT
REPORTED AS A PROBLEM, ASK: Have you/your wife ever
had dizziness/giddiness/stomach upset/nausea after
taking oral pills ?
- 1 Yes.
 - 2 No. GO TO 421
 - 8 Don't know. GO TO 421
418. What did you/your wife do about that ? Did you/she
continue taking the oral pills or did you/she stop
taking them ?
- 1 Continued taking pills
 - 2 Stopped taking pills.
 - 8 Don't know.
419. Did you/she take some other medicine to make you/her
feel better ?
- 1 Yes.
 - 2 No. GO TO 421
 - 8 Don't know. GO TO 421
420. Did the medicine help ?
- 1 Yes.
 - 2 No.
 - 8 Don't know.

421. Did you/your wife believe that the problem was caused by the oral pills or may be by something else ?
- 1 Believed it was caused by the pills.
 - 2 Believed it was caused by something else.
 - 8 Don't know.
422. IF "SCANTY MENSTRUAL BLEEDING/NO MENSTRUAL BLEEDING" WAS NOT MENTIONED AS A PROBLEM, SAY: Some women report scanty menstrual bleeding or no menstrual bleeding while taking oral pills. Has that problem ever occurred to you/your wife ?
- 1 Yes.
 - 2 No. GO TO 424
 - 8 Don't know. GO TO 424
423. What did you/your wife do about that ? Did you/she continue taking oral pills or stop ?
- 1 Continued.
 - 2 Stopped.
 - 8 Don't know.
424. How long ago did you/your wife begin taking oral pills. I mean the first time you/she ever started the very first packet ?
- _____ years ago.
- _____ months ago.
- 8 Don't know.
425. Have you/has your wife been taking the pills every month since that time or did you/she stop taking them for one month or may be longer ?
- 1 Yes. Taken them every month since then. GO TO 440
 - 2 Stopped taking them for one month or more.
 - 8 Don't know. GO TO 440.

426. For how long did she take oral pills before stopping ?

_____ years.

_____ months.

8 Don't know.

427. And why did you/your wife stop taking pills at that time. PROSE _____

8 Don't know.

428. And after stopping that time did you/your wife start taking pills again or have you/has she never used them again ?

1 Started again.

2 Never used again. GO TO 441

8 Don't know. GO TO 441

429. When did you/your wife begin using the pills again ?
How long ago ?

_____ years ago.

_____ months ago.

8 Don't know.

430. Have you/Has your wife been taking the pills every month since that time ?

1 Yes. GO TO 440

2 No.

8 Don't know. GO TO 440

431. For how long did you/your wife take the oral pills that time ?

_____ years.

_____ months.

8 Don't know.

432. Why did you/your wife stop on that occasion ? PROBE

8 Don't know.

433. After stopping that second time did you/your wife begin again ?

- 1 Yes.
- 2 No. GO TO 441
- 8 Don't know. GO TO 441

434. And have you/has your wife been taking the pills regularly since that time ?

- 1 Yes. GO TO 440
- 2 No.
- 8 Don't know. GO TO 440

435. How many more times since then have you/your wife stopped ?

- 1 Once more.
- 2 Twice more.
- 3 More than twice.
- 8 Don't know.

436. And why did you/she stop ? PROBE

- 1 _____
- 2 _____
- 8 Don't know.

437. After stopping taking the oral pill did you/or your wife begin using another method ?

- 1 Yes.
- 2 No. GO TO 439

438. Which method was that ? _____

439. Why did you not begin using another method ?

440. Are you/is your wife taking the pill these days ?

- 1 Yes.
- 2 No.

441. Do you believe you/your wife will use the oral pill in the future ?

- 1 Yes.
- 2 No.
- 3 Maybe
- 8 Don't know.

442. Why do you say that ? _____

HUSBANDS QUESTIONNAIRE GO TO 501

FOR WIVES ASK:

443. Is there a packet of oral pills in the house, now ?

- 1 Yes. GO TO 445
- 2 No.

444. IF ANSWER TO 434/440 IS "YES", ASK: Why do you not have a pack in the house now ? PROBE

_____ GO TO 448

445. May I see the packet, please ? COUNT NUMBER OF PILLS REMOVED FROM THE PACKET.

- 1 PACKET FULL .
- 2 PACKET EMPTY
- 3 PACKET PARTLY FULL : _____ PILLS REMOVED,
IN THE CORRECT ORDER. (number of pills)
- 4 PACKET PARTLY FULL : _____ PILLS REMOVED,
(number of pills)
BUT NOT IN THE CORRECT ORDER.

446. Do you intend to get another pack ? _____

- 1 Yes.
- 2 No.
- 3 Don't know.

447. Why do you say that ? PROBE

448. Let us say you were taking the oral pills regularly and your husband should go away for a few days. Would you stop taking your pills while he was away or would you continue as usual ?

- 1 I would stop.
- 2 I would continue.
- 3 Don't know.

449. When starting on a new packet of pills did you always intend to take one pill per day every day or did you intend something else ?

- 1 I intend to take one pill per day every day.
- 2 I intend something else (SPECIFY) _____
- 3 Don't know.

450. Have you noticed any changes in yourself, or in your health, since starting to take oral pills ?

- 1 Yes.
- 2 No. GO TO 501
- 8 Don't know. GO TO 501

451. What are the changes ? (SPECIFY)

- 1 _____
- 2 _____
- 3 _____

452. When you noticed a change did you keep taking the pills or did you stop taking the pills ?

- 1 I kept on taking the pills.
- 2 I stopped taking the pills.
- 3 Other (SPECIFY) _____

453. Did you discuss the changes/problems with anyone else ?

- 1 Yes.
- 2 No. GO TO 501
- 3 Don't know/don't remember. GO TO 501

454. With whom did you discuss it ?

- 1 VERBATIM _____
- 2 Anyone else ? _____
- 3 Anyone else ? _____
- 8 Don't know.

SECTION 5. ATTITUDES

501. Would you say that your wife's/husband's attitude toward the pill is:
- 1 Strongly favourable
 - 2 Quite favourable
 - 3 Neither favourable nor unfavourable
 - 4 Quite unfavourable
 - 5 Strongly unfavourable
 - 8 Don't know
502. Would you say that your own attitude toward the pill is:
- 1 Strongly favourable
 - 2 Quite favourable
 - 3 Neither favourable nor unfavourable
 - 4 Quite unfavourable
 - 5 Strongly unfavourable
 - 8 Don't know
503. After a new baby is born a woman's menstruation often does not return for some time ? What do you think is the reason for this ?
-
- 8 Don't know
504. Do you think a woman can get pregnant after a new baby is born but before her menstruation returns ?
- 1 Yes
 - 2 No
 - 8 Don't know
505. Do you think a woman can get pregnant while breast-feeding ?
- 1 Yes
 - 2 No
 - 8 Don't know

506. Do you think that oral pills have any effect upon breastfeeding ?

- 1 Yes.
- 2 No. GO TO 508
- 3 Don't know. GO TO 508

507. What effect does the pill have on breastfeeding ?

508. Have you heard about injectable contraceptives for woman ?

- 1 Yes.
- 2 No. GO TO 510
- 3 Don't know. GO TO 510

509. What is the injectable contraceptive ? Please describe it in your own words. (COPY EXACT WORDING) _____

_____ GO TO 511

510. The injectable contraceptive is a liquid given through a needle into the woman. One injection protects against pregnancy for several months. Have you heard of it ?

- 1 Yes.
- 2 No.
- 3 Don't know.

511. If an injectable contraceptive were available do you think you/your wife would want to use it or would you prefer something else ?

- 1 Would prefer the injectable.
- 2 Would prefer something else(SPECIFY) _____
- 3 Don't know.

512. Where would you/your wife be willing to have the injection: in a clinic, in a private doctor's chamber, at home, or somewhere else? MULTIPLE ANSWERS POSSIBLE

- 1 In a clinic/hospital
- 2 In a private doctor's chamber
- 3 At home
- 4 Other _____

513. Do you think most women would accept a male doctor to give her the injection?

- 1 Yes
- 2 No
- 8 Not sure/don't know

514. Which type of injection do you think would be best: one that should be given every month or one that should be given every two months? or every three months?

- 1 Injected every month
- 2 Injected every two months
- 3 Injected every three months

515. The contraceptive injection sometime causes temporary amenorrhea. What do you think a woman may wish if she has the temporary ammenorrhea after having the contraceptive injection? Will she wish to continue with the injection in future or will she wish to stop?

- 1 Probably continue
- 2 Probably stop
- 8 Don't know

516. What do you think about menstruation being stopped or diminished in quantity by a Contraceptive injection or a contraceptive pill? Do you think it is good, neither good or bad, or bad?

- 1 Good
- 2 Neither good or bad
- 3 Bad
- 8 Don't know

517. Sometimes -- very rarely -- a woman may have heavy menstrual bleeding after having a contraceptive injection. What do you think a woman may wish if she knows she may have very heavy bleeding after the injection? Do you think she would still want to use the injection, or would she probably prefer not to use the injection?

- 1 She would still want to use the contraceptive injection.
- 2 She would probably not want to use the injection
- 3 Don't know

518. If you want to get advice about any contraceptive problem who would you go to first?

VERBATIM _____

519. Anyone else _____

SECTION 6. CHILDBEARING HISTORY (FOR WOMEN ONLY)

601. Now, I would like to ask you some questions about child-bearing and family planning. Have you ever given birth to a child? (IF THE RESPONSE IS 'NO', ASK: I mean even a child who died immediately after its birth).
- 1 Yes.
2 No. GO TO 608.
602. How many of your own children are living with you?
(SPECIFY NUMBER) _____.
603. How many of your own children do not live with you?
(SPECIFY NUMBER) _____.
604. Thus, you now have a total number of _____ living children. (CONFIRM WITH RESPONDENT THAT THIS IS THE CORRECT NUMBER). How many are boys and how many are girls?
- _____ boys.
_____ girls.
605. Have you ever given birth to a child who, God forbid, later died, including those children who died immediately after birth?
- 1 Yes.
2 No. GO TO 607.
606. How many of your children have died? (SPECIFY NUMBER _____).
607. (TOTAL THE NUMBER OF CHILDREN IN 604 AND 606). I find from your responses that so far you have had _____ live births. (CONFIRM THAT THIS IS THE CORRECT NUMBER).
608. Is this your first marriage?
- 1 Yes. GO TO 610
2 No.

609. For how many years altogether have you been married ?

(Interviewer: GO TO 618a, if answer to 601 is 'No' or
if is zero in 604)

610. How old is your youngest living child ? _____

611. And did you take the oral pills after the baby was born ?

- 1 Yes
- 2 No GO TO 616

612. How old was the baby when you started taking the pills ?

AGE _____

613. Had your menstruation returned when you started the pills ?

- 1 Yes
- 2 No
- 8 Can't recall

614. Did you breastfeed that baby ?

- 1 Yes
- 2 No GO TO 617

615. Were you breastfeeding when you started the pills ?

- 1 Yes
- 2 No GO TO 617
- 8 Don't know

616. Are you breastfeeding now ?

- 1 Yes
- 2 No

617. Did you become pregnant again since that baby was born ?

- 1 Yes. GO TO 618b
- 2 No. GO TO 620

618a. Are you pregnant now ?

1 Yes

2 No

(GO TO 701)

618b. Are you pregnant now ?

1 Yes GO TO 620

2 No

619. How did that pregnancy end ?

1 Miscarriage

2 Abortion

3 Live birth but died soon after

9 No response

620. How many weeks or months ago did your last menses begin ?

_____ week ago.

_____ months ago.

124

SECTION-7: PAST USERS

701. Do you know of anyone who has used the oral pill in the past but has stopped ?

1 Yes

2 No

(Terminate the interview with thanks)

702. How many such women do you know yourself ?

(Number)

703. Please give me their names and addresses.

(Terminate the interview with thanks)

ORAL CONTRACEPTIVE MARKETING IN BANGLADESH
VOLUME II. RESULTS, POLICY IMPLICATIONS AND RECOMMENDATIONS

FINAL REPORT

Prepared for: The Bangladesh Family Planning Social Marketing
Project and Population Service International.

Prepared by : J. Davies, Consultant, Honolulu.

Supported by: Office of Population and Health, USAID Mission
to Bangladesh.

Honolulu, December, 1984

ACKNOWLEDGEMENTS

The study is a joint effort of the Social Marketing Project management, USAID office of Population and Health/Bangladesh, Population Services International, Mitra and Associates, and John Davies, Family Planning Consultant. The authors wish to thank Mr. S. Anwar Ali, Mr. W.P.Schellstede and the management of the project for their continuing helpful participation. We are grateful also for the financial support of USAID and particularly wish to thank Mr. John Thomas and Dr. Carol Carpenter of the USAID Mission to Bangladesh for their helpful comments and technical suggestions during the planning stage. We hope that the results of the study will be a suitable reward for the efforts of all the participants.

John Davies, Principal Investigator

S.N. Mitra, Executive Director
Mitra and Associates

INTRODUCTION

This report has been produced in three volumes for ease of distribution and reading. The volumes are:

- I. Background, Summary Tables and Questionnaires
- II. Results, Policy Implications and Recommendations
- III. Executive Summary.

The report was produced by John Davies, the Principal Investigator, and S.N. Mitra, Mitra and Associates, Dhaka Bangladesh. This volume was produced and written by the Principal Investigator. A more complete description of the background to the research, including the responsibilities of the two investigators can be found in Volume I.

Importantly, the stratification of providers used in this report differs from the original design which was adhered to in the Interim Report; the number of groups of providers has been collapsed from five to three in this report. Thus, the tables and percentage values used in this report often differ from those used in the Interim Report. The Interim Report adhered to the stratification used in sampling, namely, five categories as supplied to the researchers by the SMP management. As discussed more fully in Volume I, the reduction in number of groups was possible because of similarities between certain groups. Quality of the data has not suffered by reducing the number of groups, but the results are probably much more useful for strategic market planning using the new, simpler categorization. The stratification system used in this Final Report contains the following three categories:

1. Doctors (with a medical degree --N=45)
2. Health Practitioners (usually called "doctors" but without a degree --N=49)
3. Pharmacists (operating a pharmacy/chemist shop with or without a degree --N=29.)

Chapters 1 to 5 use the stratification described above to focus on the three major study groups, namely providers, current users of oral contraceptives (OCs), and husbands of the current users. Chapter 6 describes and discusses past users and their husbands, comparing and contrasting the few differences between past and current users. Chapter 7 contains the results of a special analysis of current users and husbands by their usual provider, plus results of an analysis of rural users and their husbands. Chapter 8 contains policy implications and recommendations based upon the results reported in the first seven chapters.

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Chapter 1

PROVIDERS, USERS AND HUSBANDS

This Chapter addresses the following research objective:

- To identify and describe the social and economic characteristics of the Social Marketing Project's oral contraceptive providers, users and husbands of users.

Every respondent was asked a series of questions about demographic, social and economic characteristics. Users were also asked about reproductive history.

The results were synthesized into profiles which can be used for market planning. The profile of providers is followed by the profile of current users and lastly, of husbands of current users.

1.1 PROFILE OF THE PROVIDERS (Table 1.1)

Similarities

The following characteristics were common to all three types of providers, with only small differences between types.

All providers were men. Most (68%) were under 40 years of age. Most (89%) were married, and most (89%) were Muslims; the remainder were Hindus. All reported that they were either the proprietors or the managers of the business and that they had discussed oral contraceptives with an SMP representative. Most (92%) said that this occupation was full-time. On average they had been in the present occupation for 8 years, although there was a very large range.

Differences

The three categories of providers differed in several ways, as follows:

Doctors. Mostly as a result of the sampling design half of the doctors worked in urban areas and half in rural areas. Nearly all Doctors (96%) had medical degrees; this was also a result of the sampling design since Doctors were defined as having degrees. All doctors said their main activity was advising people, not selling medicines.

Health Practitioners. Again, partly as a result of the sampling design, most

differed from doctors; only 12% had medical degrees (not university degrees) while another 37% had attended or graduated from college; the remainder had completed high school. Like the Doctors, most (86%) said their main activity was advising people, as opposed to selling medicines.

Pharmacists. Like the Health Practitioners, 59% of the pharmacists worked in rural areas and the remainder worked in urban areas. Their education level was higher than the Health Practitioners': the majority (62) percent had attended or completed college, while the remainder had completed high school. Unlike the other two types of providers only 21% reported their main activity as advising people; the remainder (79%) said their main occupation was selling medicines.

COMMENTS

Two characteristics of the providers are worth noting: education and main occupation. The educational level of all providers was high school graduation or better. Given the general education level in Bangladesh, these men are well-educated and therefore probably well-respected. The providers' education is probably most useful to the SMP in rural areas where they can read and pass on oral contraceptive (OC) instructions to their customers and clients.

The self-reported main activities of the providers may be as important to marketing strategists as the nominal tags of "Doctor", "Quack", or "Pharmacist" used in the study, because "advising people" and "selling medicines" imply very different relationships between a provider and his customers, patients or clients. Based on this difference, the Doctors and the Health Practitioners should be in a better position than the Pharmacists to instruct people about OC use and side-effects. For some purposes the Doctors and Health Practitioners might be considered similarly -- as doctors -- one with a university degree and one without. Then we would be dealing with only two categories: those whose main occupation is advising their patients, and those whose main occupation is selling medicines.

1.2 PROFILE OF CURRENT USERS (TABLE 1.2)

As described in Volume 1, the providers were the primary sample, that is, they were selected first, on a random basis. After being interviewed, each provider was asked to name OC users whom he had served. The users and their husbands were then sought out and interviewed simultaneously, but separately. Throughout the analysis the users and their husbands were categorized according to the type of provider who identified them.

General

The following characteristics were common to all three groups of current users.

Socially, all current users were married and living with their husbands. The

majority (87%) were Muslims, the remainder were Hindus. The age range was broad -- from 14 to 43 years -- but only 13% were under 20 and only 8% were over 35; thus, about four out of five (79%) were between 20 and 35. The mean age was 26. The mean age at marriage was 15 years. The mean duration of marriage was 12 years.

Economically, a small proportion (10%) were employed outside their homes and were paid for their employment, while 79% of their husbands' families owned land. About one out of five reported a television in the household, while 84% reported having seen TV. More than three out of five (63%) reported having a radio in the household, while 96% reported listening to radio.

Reproductively, nearly all (96%) had given birth. Thirteen percent had had one birth, 25% two births, 19% three births, 15% four births, 10% five births, 6% six births, and 8% had had six or more births. The mean and median numbers of births were three; a "typical" mother (typical of the middle half of the sample between the 25th and 75th centiles) had 2, 3 or 4 children.

Child mortality had occurred to 27% of the women; 19% had experienced one child death while 6% had experienced two child deaths, and 2% had three or four.

The number of living children per mother ranged from 0 - 14. Only 5 % of the mothers had no living children; 15% had one child; 29% had two; 20% had three; 16% had four, 7% had five, and 8% had six or more. The mean and median were three; A "typical" mother (in the mid-half between the 25th and 75th percentiles) had either 2, 3, or 4 children.

The age of the youngest child ranged from one to fifteen years; the mean and median were three years, while the youngest child of a "typical" mother was between two and five years old.

Seven percent of the users said they had become pregnant since their last birth but only 2% were currently pregnant. In a later analysis they were moved to the past users sample.

Differences Between Groups

There were noticeable, but not large, differences in two variables -- education and television ownership.

Education (C108, C109, C110). The majority of users (81%) had attended school. Thirty percent had completed primary school; 31% had completed grade 6 - 9; 18% high school; and 2% university. However, the Pharmacists' customers were better educated; 87% had attended school and larger proportions had completed grades 6 - 9 as well as high school.

Television (C116, C117) While 21% reported having a television in the household, the proportion was lower for Health Practitioners' customers (15%) and higher for Pharmacists' customers (27%). Similarly, 84% of the users said they had ever watched TV; the Health Practitioners' customers were a little lower (80%) and the Pharmacists' customers were a little higher (91%).

COMMENTS

The timing of contraception in relation to age and fertility is important. The large majority of users were contracepting during the prime reproductive

perspectives; OCs are safest for women under 35, while successful contraception during these prime years implies lower completed family size than would otherwise occur.

1.3 PROFILE OF THE USERS' HUSBANDS (Table 1.3)

General

The following characteristics were common to the entire sample of husbands of current users.

All husbands were currently married and living with their spouse. The majority (87%) were Muslims, the remainder Hindus. Their ages ranged from 20 to more than 50 years, with a mean of 36. The mean age at marriage was 24 and the mean duration of marriage was 12 years. About four out of five (79%) reported that their families owned land.

Differences Between Groups

When examined by the type of provider who identified them, there were two noticeable differences between the groups: education and occupation.

Education (C108, C109, C110). Nearly all husbands (92%) had attended school. Thirteen percent had completed primary, 21% had completed grades 6 - 9, 37% high school, and 20% had university or professional degrees. Like their wives, Pharmacy customers had significantly better education; 99% had attended school while more had completed high school and professional degrees.

Occupation (C114). Husbands reported their occupations as follows: 19% agriculture, 48% business, 31% service or government, and 2% professional. But there were noticeable differences between groups: more of the Health Practitioners customers (27%) were agriculturists. On the other hand, only 7% of the husbands named by Pharmacists were agriculturists, while more than three out of five (61%) were in business, and 29% were in service or government work.

COMMENTS

The husbands' profile gives a useful indication of social status for the group as well as for customers of the three types of providers. It also compares well with the users' profile and suggests that the results of the study are probably generalizable to a larger Bangladeshi population.

Social Status. Husbands' education, in combination with the users' education, is particularly worth noting. Although a substantial proportion of the users may not be able to read CC promotional literature or instructions, the majority of their husbands probably can. Assuming a reasonable level of communication between husband and wife, this factor means that husbands can assist their wives to understand correct instructions for taking the pills.

While the educational range is large, the average is higher than that of the population as a whole (Chowdhury & Jayasuriya, 1981), indicating a middle-class status for these couples. The higher education of the Pharmacists' customers is significant. The middle-class status is also reflected in husbands' occupations; a large proportion work in business or service sectors, including government, as opposed to agriculture. This finding is not dictated by the sampling design; the rural proportion occupied in agriculture was also much lower than the national average (Alamgir, 1981). Similarly, the higher than average TV ownership indicates middle-class status (Manoff International, 1983).

While differences between the three groups were not large, there was a pattern; Pharmacists' customers were better educated. Larger proportions worked in the business sector and owned televisions.

Validity, Reliability and Generalizability. Based upon these results the validity and reliability of the study appears to be high. For example, the user data are reflected in and reinforced by the husband data in several variables including combinations of age, age at marriage, and duration of marriage. Furthermore, some of the results reflect the findings of other studies of OC users in Bangladesh, therefore indicating generalizability of the results (Alauddin & Faruqee, 1983; MIS, 1983). Thus, the strategy described in Volume I of sampling an area judged by SMP management to be generally representative of nationwide OC marketing patterns, seems well justified on the basis of the results. Lastly, the value of including separate but simultaneous interviews of users and husbands has been confirmed. In addition to providing useful substantive information from and about husbands, the interviewing technique allows for ready comparisons between husbands' and users' responses in a country where survey validity and reliability have been found less than satisfactory (Thompson, Ali & Casterline, 1982; COPD, 1981). This technique was developed and found useful by other family planning researchers in Bangladesh (Ahmed & Williamson, 1984; Mitra, 1984).

Chapter 2

SELLING AND PURCHASING PATTERNS

This Chapter addresses the following research objectives:

- To identify and describe the roles of SMP providers in stocking and selling oral contraceptives,
- To identify and describe the roles of users and users' husbands in purchasing oral contraceptives.

2.1 PROVIDERS' STOCKING PATTERNS (Table 2.1)

The providers were asked a series of questions about stocking OCs, including how long they had stocked OCs, sales volumes, the number of brands stocked, brand names stocked, the brand most often sold, and the reasons for the higher sales volume of that brand.

Duration of Stocking OCs (P213)

Some providers had stocked OCs for less than a year; others had stocked for up to seven years. The average duration of stocking the SMP brands was four years. There were no large differences by type of provider.

Sales Volumes (P206)

As expected from SMP sales reports, there were large differences in sales volumes between types of providers. On average, Doctors reported selling only 15 packets during the past four weeks. Health Practitioners, on the other hand, reported an average sales volume of 38, while Pharmacists reported an average of 93 packets during the same period.

Numbers of Brands Usually Stocked (P202)

There was a range of from one to five brands stocked but most providers stocked either three or four different brands. A few Doctors did not normally stock OCs although they had discussed them with SMP representatives and prescribed them.

Brand Names Stocked (P201)

About four out of five providers (78%) stocked Maya, while 84% stocked Ovacon and 84% stocked Ovostat. The majority (55%) also stocked Lyndiol. This group pattern also held quite well for the different types of providers, except that virtually all Pharmacists stocked Ovacon and Ovostat. Noriday was stocked by 27% of the Doctors.

Brands Most Often Sold (P203)

For the group as a whole, only three brands accounted for almost 90% of the "products of choice", namely, Maya, Ovacon and Ovostat. Ovostat was the sales leader for 46% of the providers, while Ovacon led for 23% and Maya for 20%. The Pharmacists differed most noticeably from this pattern; 76% reported that Ovostat was the brand they most often sold.

Reasons for Popularity of that Brand (P204, P205)

As a group, providers related popularity mostly to product attributes such as few side-effects (56%), "most suitable for the user" (24%), and "low dose" (15%). Thirty percent also gave "low cost" as a reason for popularity.

There were no very large differences between the different types of providers; the issue of few side effects was paramount for all. Low cost was mentioned by those who said Maya or Ovacon were their best sellers.

COMMENTS

There were few surprises in the stocking patterns or sales patterns, but the figures do help to emphasize the differences between the types of providers. Doctors, as a group, carry several different brands including Noriday, the government formulation, but have very low sales volumes. Health Practitioners and Pharmacists tend to stock only the three leading brands, namely, Maya, Ovacon and Ovostat, but have larger sales volumes than Doctors. Pharmacists emphasize Ovostat.

According to the providers, high popularity is most often associated with a low incidence of side effects. If this is true, then many users report few side effects from the regular dose pills, including Ovostat and Maya, as well as from Ovacon, the only low dose pill among the three most popular brands.

2.2 IDENTITY OF THE PURCHASERS (Table 2.2)

Providers and couples were asked about who usually purchased OCs. Users and

for supplies or whether their supplies were delivered to their homestead.

Identity of Purchasers (P211, C201)

Seventy percent of the providers said the usual purchaser was the husband. The remaining 30% said it was the user. However, only Health Practitioners and Pharmacists answered most strongly in favor of husbands (84% and 86%, respectively). The Doctors were different; only 44% answered the same way. The other 56% said the usual purchaser was the user, herself.

This response pattern was validated by the couples; 68% of the users and 69% of the husbands said the husbands usually obtained the pills.

Procurement Vs. Home Delivery of Supplies (C206)

The couples were asked whether they usually went out to get the supplies or whether they were usually delivered. More than three out of four (78% of the users and 76% of the husbands) responded that the pills were procured from the provider's place of business. The remainder said that the Family Planning Worker usually delivered the pills to the homestead. More Pharmacists' customers (91%) said they usually procured their own supplies.

COMMENTS

The overriding importance of the husband as the purchaser is shown here. Even when the women "obtained" supplies, it usually meant they were delivered by the Family Planning Worker. Thus, very few women actually shop for OCs. While this is no surprise -- women don't generally shop in Bangladesh -- it does show the importance of men in the OC chain. The typical user of commercial sector OCs depends upon her husband to purchase her pills from a another man and provide her with a continuing supply.

2.3 BRANDS OBTAINED BY THE COUPLES (Table 2.3)

A series of questions was asked of the users and their husbands about the number of brands ever used, specific brands purchased, preferred brands and reasons for preferences.

Number of Brands Ever Used (C215)

Forty-seven percent of the users reported loyalty to one brand, that is, they said they had always used the same brand. Another 33% reported ever using two brands while 20% reported having used more than two brands. Husbands reported

similarly. There were no significant differences when the users or husbands were grouped by type of provider.

Brands used by the Loyal Consumers (C214)

Sixteen percent of the users reported loyalty to Ovostat, 13% to Noriday, 8% to Maya, 5% to Ovacon, and 4% to other brands. As noted, another 53% had used more than one brand. Husbands reports were similar.

There were differences by type of provider: 20% of the Doctors' customers said they always used Noriday, 23% of the Pharmacists' customers said they always used Ovostat, and 18% of the Health Practitioners' customers reported always purchasing SMP products-- 10% used Maya, and 8% used Ovacon. Husbands reported similarly.

Brands Used by the Non-loyal Consumers (C216).

In combination with one or more other brands, 40% of the users had used Ovostat, 24% had used Ovacon, 22% Maya, 18% Lyndiol, and 6% had used other brands. As noted, a further 47% had used only one brand. Husbands answered similarly. There were no noticeable differences by provider group.

Preferred Brands of the Non-loyal Sample (C217)

Twenty-one percent of the users said that Ovostat was their brand of choice, 9% said Ovacon, 6% said Noriday and 3% said Maya. Husbands reported approximately the same way, and there were no substantial differences by provider type.

Reasons for Brand Preference (C218)

Three out of four users (75%) reportedly use their preferred brand because it had "few side effects" or "no side effects." The next most frequent response (only 12%) was "free of cost" Only 6% said that effectiveness was a reason, and only 5% said that their provider had suggested the particular brand.

COMMENTS

Two findings are noteworthy here, namely, the high popularity of Ovostat and the importance of side effects in choosing a brand.

Of the four most commonly used brands, Ovostat was definitely the most popular, being used or preferred by almost two out of five users (37%). Noriday was the next most popular, being used or preferred by 19% of the users. Ovacon was used or preferred by 14%, while Maya was used or preferred by another 11%. Thus, the two SMP brands, when combined, accounted for the "brands of choice" of one out of four users. This pattern of brand shares approximates the national picture as reflected by distribution reports.

Side effects are important to these users and their husbands; it appears as the most important reason in choosing a brand, as it did to the providers. Perhaps brand-switching is the result of a search for a brand which is low in side effects.

2.4 DURATION OF USE (Table 4.1)

Users and husbands were asked a series of questions about their duration of use and continuity of use. Responses are reviewed briefly here to illustrate the discussion about choices of brands and providers. A more detailed discussion of duration and continuity of use is included in Chapter 4.

Duration and Continuity of Use (C424, C425)

There was a large range of duration of use: from less than one year to twenty years. Mean duration since first use was 53 months according to users, and 56 months according to husbands. "Typical" users (between the 25th and 75th centiles) began between two years and six years ago.

Almost exactly half of the users said they had continued without a break to the time of the survey. The other 50% had discontinued one or more times.

COMMENTS

As might be expected from the sampling design used for this study, there was a large range of durations of use, but the average duration of use was several years, perhaps longer than most in Bangladesh, because providers might more easily remember and identify users who had been purchasing for longer periods of time.

2.5 CHOOSING A PROVIDER (Table 2.4)

Users and husbands were asked a series of questions about their providers, including the first provider, usual provider and other providers. Providers were asked one question about who they thought user couples purchased from.

Provider of the First Packet (C225)

Overall, 37% of the users said that the Pharmacy was the provider of the first pack ever used. Family planning workers (31%) were a close second. Other providers were reported much less often: Doctors by 9%, Health Practitioners by 8% and others by 4%. The remaining 11% said they did not know the type of first provider. The husbands' responses fit a similar pattern although only 1% said they did not know the first type of provider. Of the husbands, 45%

Interestingly, there were few large differences by type of provider. For example, while 3% of all users said their first provider was a Health Practitioner, only 14% of the Health Practitioners' "customers" (as identified by Health Practitioners) said they first obtained OCs from a Health Practitioner. But 37% of the Health Practitioners' "customers" reported obtaining their first supply from Family Planning Workers, and 26% said they obtained their first supply from a Pharmacy. The pattern for the Doctors group was similar. This pattern was reinforced by the husbands' responses. Thus, almost three out of four users reportedly obtained their first OCs from either a Pharmacy or a Family Planning Worker.

Usual Providers of Continuing Supplies (P212, C203)

When providers were asked where they thought most continuing users would go to obtain more supplies, 31% said "me" or "my assistant." The responses did not vary greatly between provider types.

When a similar question was put to users, 39% said the usual provider was the pharmacy, and 28% said it was the Family Planning Worker. Each of the other types of provider was mentioned by less than 10% of the users while 12% said they did not know. Again, the husbands responded similarly, but none said he did not know; almost one out of every two (48%) said the usual source was the pharmacy, including 79% of the those who were named by Pharmacists. Another 28% said the usual source was the Family Planning Worker. Examining any of the three provider strata showed that 72% or more of these couples usually obtained OCs from a Pharmacy or a Family Planning Worker.

Obtaining from Other Providers (C204, C205)

Only 21% of the users said their pills had ever been obtained from a source other than the usual provider. But the husbands reported differently: almost half (49%) said their pills had been obtained from some other source at least once.

Users named Pharmacies and Family Planning Workers about equally but the vast majority of husbands named Pharmacies.

Reasons for Choosing a Provider (C226)

This question was asked of the fairly small percentage who had said their usual provider was different from their first provider. There were only three responses: ease of availability (8% of the users and 9% of the husbands), free of charge (4% and 7%, respectively) and doctors' advice (2% and 5% respectively).

COMMENTS

These findings are very useful for two reasons; firstly, they show the

sample is surprisingly similar to the national sample in its choice of providers.

Pharmacies and Family Planning Workers are overwhelmingly important as providers of OCs, in spite of the fact that the sample of couples was drawn by Doctors, Health Practitioners and Pharmacists. While the Doctors and Health Practitioners could identify user couples, most of those couples obtained their first supplies and their continuing supplies from Pharmacies and Family Planning Workers. Thus, the sample reflects the national picture rather well, as described in the 1983 Contraceptive Prevalence Survey (Mitra, 1984), where half of the husbands reported Pharmacies as the source of supply for OCs and half reported either Family Planning Workers or Clinics.

These results are probably more useful than anticipated; not only is a picture of the SMP providers developing, but the users appear to be representative of a nationwide group; first in social and economic ways, as discussed in the first Chapter, now in their relationship with the Bangladesh distribution system.

2.6 AVAILABILITY OF SUPPLIES (Table 2.5)

Users and their husbands were asked a series of questions about the ease or difficulty of obtaining their OCs. Questions included the method of travel to the provider, travel time, perceived difficulty of travel, availability at the usual place, reasons for non-availability, and suggestions for improved availability.

The husbands' responses are reported here because they were the usual purchasers. Users' responses did not vary much from the husbands', except for some "don't know's". The results showed no meaningful differences by type of provider.

Method of Travel to the Provider. (C207)

More than half (55%) of the husbands said the usual method of travel to the usual provider was walking. Another 21% reported riding while, as noted earlier, 24% reported that Family Planning Workers delivered their supplies.

Travel Time to the Providers (C208)

About half of the husbands' group (49%) said travel time was less than ten minutes. Another one-fourth (27%) said they needed ten or more minutes. The remaining 24% reported that Family Planning Workers delivered their supplies, as noted above.

Perceived Difficulty of Travelling to the Provider (C209)

Only 6% of the husbands said travel was difficult. The remainder said travel was not difficult.

Only 9% of the husbands said that OCs were sometimes unavailable; 90% said they were always available.

Reasons for Non-availability (C211)

Only 9% of the husbands were eligible for this question. The majority (7%) said "out-of-stock" was the usual reason for non-availability.

Suggested Improvements for Supply (C212)

Three out of five husbands (60%) suggested home delivery and 22% said that stocks should be assured. Another 5% suggested lower prices.

COMMENTS

An important aspect of availability is travel time; it has been associated with contraceptive use in other studies (Rodriguez, 1979). With half of the sample travelling for less than 10 minutes and another quarter having home delivery, most of the sample could be said to have adequate availability, a conclusion that was reinforced when only 6% said that travelling to the provider was difficult.

There are at least two noteworthy aspects to this finding of good availability. Firstly, all of the sample were users, including many long-term users; presumably users would perceive availability as being better or easier than non-users or past users would. This issue is included in the discussion of past users in Chapter 6. Secondly, good distribution & supply is a hallmark of successful product marketing, and a specific strength of the SMP (Davies, 1983; Schellstede & Ciszewski, 1984); it is quite probable that the improved OC sales record of the SMP since 1981 has been the result of improved availability.

Another example of ready availability is the home delivery offered by government Family Planning Workers. A substantial proportion of the sample received supplies through that system, while 60% of the sample suggested it as an improvement. Such a system offers at least two advantages: (1) it comes close to maximizing "availability" by eliminating travel, and (2) it allows for additional contact between a provider and a user, thereby implying better compliance with dosage instructions plus the possibility of longer continuation and more effective use. Such systems are used by government in Bangladesh and by non-government programs (Phillips, et al, 1984). Furthermore, evaluation of an SMP test market of door to door delivery showed increased prevalence in the area (Schellstede and Ciszewski, 1984). Thus, from the available evidence in Bangladesh, home delivery is an effective method of improving prevalence of female methods of family planning.

2.7 MULTIPLE SALES AND PURCHASES (Table 2.6)

Users and users' husbands were asked several questions about purchasing more than one packet at a time. Providers were asked fewer questions on the same topic. Questions included the availability of pills in the house when the first pack was finished, advisability of purchasing more than one pack at a time, and whether couples had purchased more than one pack at a time. Only husbands' and providers' responses are used here because husbands were found to do most of the purchasing and because users' responses did not vary meaningfully from their husbands' responses.

Multiple Purchases by Couples (C221)

About half of the husbands (44%) reported that more than one pack had been obtained on at least one occasion. Additional analysis showed that most of these couples obtained their supplies from the government system.

Additional Supplies in the Household (C220)

Forty percent of the husbands reported that another packet was usually in the house when the current packet was finished. Only 2% reported that they did not know, while the remaining 58% reported that another packet was not available. Again, most of the couples who had additional supplies obtained their supplies from the government system.

Willingness of Continuing Users to Purchase Two Packets (C224)

About three out of every five husbands (63%) said they thought continuing users would be willing to purchase two packets at a time.

Providers' Perspectives on Multiple Sales (P209, P210)

Virtually all (95%) of the providers said it was a good idea for a new user to obtain more than one pack at the time of first purchase. Two out of every five providers (39%) said that a new user couple would probably be willing to purchase two packets on the first occasion, but there were large differences by provider; while 58% of the Doctors felt positive about the idea, only 35% of the Health Practitioners and a mere 17% of the Pharmacists agreed.

COMMENTS

To help ensure effectiveness, a new packet of Maya or Ovacon or Noriday should be started the day after the last packet is finished. Where a couple commonly purchases the next packet after the current packet is finished and thereby delays the routine start of another cycle, there is an increased chance of

lowering the effectiveness of contraception. It appears from these results that some users do not always have a fresh pack waiting to be used immediately after the current pack is finished; therefore, on average, effectiveness is probably lower.

One method of helping to ensure having additional stocks-on-hand in the household is to encourage the sale of more than one packet at a time. This can be promoted by the marketing organization by offering lower prices on multiple purchases, for example by packaging two cycles in a packet. This has been done with "Blue Lady" supplies; it has also been tried successfully in a social marketing project (PSI). While the system can be abused by retailers if there is a large enough monetary incentive to split packages and sell individual cycles for a higher profit per cycle, the abuse can be minimized by heavy advertising of the two-cycle price.

Another way of increasing the prevalence of overlapping supplies at the household level is by door-to-door selling. If a seller is on a thirty-day sales route it is clear to the user that she must purchase in advance to assure a continuing supply. The visit of the seller is an added reminder and incentive to buy another packet.

The high degree of willingness to purchase two cycles at a time, as expressed by the husbands in this survey, should not be taken as a quantitative target for multiple sales. The reality would probably be less than these figures imply unless the SMP made OCs available only in multiple packets. But the issue is worth pursuing in the continuing search for improved compliance and longer continuity rates. These two concepts are at the heart of effective fertility control with OCs.

A particularly useful time to offer two or more cycles is during the first sale. The offer should be coupled with the advice to persist in taking the pills even if nausea or dizziness occurs with the first cycle, or if menstrual patterns change. Coupling this advice to the sale of the second cycle should enhance the probability of the second cycle being used; side effects during the second cycle should be less than those during the first cycle. A secondary advantage could be lower packaging costs.

Chapter 3

INSTRUCTORS AND INSTRUCTIONS

This Chapter addresses the following research objectives:

- To identify and describe instructions about OCs that flow from SMP providers to the users,
- To identify and describe OC knowledge among users and husbands of users,
- To identify and describe the roles of providers and users' husbands in communicating knowledge of OCs to the users.

The SMP has stressed one medium for instructing users on the correct use of Maya and Ovacon, namely, specific people in the distribution chain. The SMP trains all Sales Representatives and Medical Representatives for eight days on the use of OCs. These representatives are similar to "medical detail men" in Western countries; they call on Doctors, Health Practitioners and Pharmacists, explaining and promoting the sale and use of Maya and Ovacon. They also convene and address groups of Health Practitioners during a half-day "Conference", during which they introduce OCs, explain their correct use, answer questions, and sell a supply to the participants. This system of training SMP providers, who in turn pass on information to purchasers, is supplemented by printed packet inserts.

Mass media, such as television, radio and print are used to promote awareness and use of Maya and Ovacon, and to provide some specific information on correct use, but are limited in their ability to provide all necessary instructions and warnings. A radio spot, seven seconds long, is broadcast each night at 10:00 P.M., reminding users to take their pill.

3.1 PROVIDERS' PERSPECTIVES ON CUSTOMERS (Table 3.1)

The providers were asked a series of questions about the types of discussions they have with customers about OCs, including whether the discussions are with the wife or husband, whether customers ask for advice on method choice and the method usually suggested.

Providers' Relationship with Users and Husbands (P305)

Eighty percent of the providers said they first discussed OCs with husbands;

only 19% said they first discussed OCs with the wife. There were significant differences between providers; 33% of the Doctors, 14% of the Health Practitioners and 7% of the Pharmacists said they first discussed OCs with the wife.

Providers' Perception of Customers' Needs for Advice (P301)

Thirty percent of the providers said that customers usually know which method they want, while 70% said customers usually ask for advice. There were significant differences between providers; 67% of the Doctors and 88% of the HP said that customers usually asked advice, but only 45% of the Pharmacists answered similarly.

Method Usually Suggested (P303)

As a group, 72% of the providers said they suggested OCs. Other methods were suggested by a trivial proportion of providers. There were no large differences by type of provider.

Perceived Sources of Couples' First OC Knowledge (P304)

Only 36% of the providers said that they themselves provided the first knowledge of OCs to customers; the remaining 64% said it was someone else. Even fewer Doctors (16%) said they provided the first knowledge.

COMMENTS

These results illustrate that most providers may influence customers to begin use of OCs, but that the majority of contacts are with husbands, rather than with users themselves.

The emphasis reportedly placed on OCs by the providers (P303) should probably be discounted because the providers may have perceived the emphasis placed on OCs by the interviewers during the preceding sections of the questionnaire and might then reflect that emphasis in their answer.

3.2 SOURCES OF COUPLES' KNOWLEDGE (Table 3.2)

Couples were asked about their sources of OC knowledge. Responses of users and husbands are compared here.

Quantity of Interspouse Communication (C303)

When asked about how much discussion with their spouses had preceded OC use,

Only 5% of the users said "none at all." The remainder of the responses were about evenly spread between "only a little", "not much", "quite a lot" and "very much".

Husbands responses were a little more positive; more than half (53%) said "quite a lot" or "very much." There were no large differences by provider groups.

Source of Most Knowledge (C301)

When users and husbands were asked for the single major source of knowledge about how and when the user should take OCs, almost half (46%) of the users said it was her husband, while 28% said it was the Family Planning Worker, and 12% said it was a relative, neighbor or friend. Another 7% said it was the printed packet insert. There were only minor differences when users were classified by type of provider. Those who said it was the Family Planning Worker were mostly users of the government system.

The husbands responses were approximately the same, with a little less emphasis on their own role as instructor. Twelve percent said Doctors were the most important source and 6% said HP were the most important source. Only a trivial proportion suggested the Pharmacist.

Other Sources of Instruction (C302)

When asked to name another source of instruction 75% of the users and 61% of their husbands said "none." Eight percent of the husbands said they did not know. The quantities of any other answers were trivial.

Role of the First Provider as an Instructor (C304)

A minority of users (38%) said the provider of the first packet had given instructions for use; 60% said the first provider had not given instructions.

Husbands were a little more positive; half said the provider had given instructions.

First Instructors, Other Than Providers (C305)

Responses of both users and husbands indicated that, other than the first provider, husbands were the major instructors; 43% of the users said her husband was the major instructor.

COMMENTS

This information complements the information given by the providers on the same topics. According to many users commercial sector providers of first packets do not instruct users on OC use. Husbands and Family Planning Workers were the sources of information to most users.

The responses of husbands are enlightening. It appears that for those couples who use commercial supplies, rather than government supplies, the husband is the main source of information. The sources of his information vary, but do not always include the first provider.

The fact that the majority of husbands and wives agreed that they communicated before ever using OCs indicates that there was an early opportunity for husbands to pass information to wives.

3.3 IDENTIFYING THE FIRST PILL (Table 3.3)

A series of questions was asked of all respondents about instructions given at the time of the first purchase. The first issue concerned which pill in the packet should be swallowed first. Respondents were also shown a packet and asked to point to the pill which should be swallowed first. Comparisons are offered here of answers given by providers, users and husbands.

Whether the Instruction Was Given (P309, C309)

Ninety-five percent of the providers said they gave instructions at the time of the first sale about which pill should be taken first. Eighty-eight percent of the users and 76 percent of the husbands said that such instructions were given. There were no noticeable differences by type of provider.

Whether Told or Shown (P310, C310)

The majority of providers, users and husbands (76%, 83% & 61%, respectively) said "shown". There were no noticeable differences by type of provider.

Actual Instructions Given, When Not Told (P311, C311)

Those few users and couples who had said they were told, were asked about the specific instructions given. Most answered, "the pill marked by the arrow".

Pointing to the First Pill Correctly (P312, C312)

Of the providers, 83% correctly identified the first pill, but there was a noticeable difference between types of providers. While 89% of the Doctors and 86% of the Pharmacists were correct, only 75% of the Health Practitioners pointed correctly. Of the users, 90% pointed correctly, while 79% of their husbands pointed correctly, 11% pointed incorrectly and 10% said they didn't know.

COMMENTS

While the majority of providers and couples know which pill should be taken first there were noticeable deficiencies in the proportions who could point correctly. While some of the 10% deficiency in the users may have occurred because they were shown a different pack than they were accustomed to, it is difficult to discount provider deficiencies for the same reason, or for other reasons. While none of the providers said "I don't know", one out of four Health Practitioners apparently could not instruct his clients correctly.

3.4 IDENTIFYING THE CORRECT DAY TO BEGIN (Table 3.4)

As for the previous issue, all respondents were asked a series of questions about which day the first pill should be taken.

Whether This Instruction Was Given (P306, C306)

While 97% of the providers said they instructed customers at the time of first purchase about which day to take the first pill, slightly fewer users (92%) said they had been instructed while 78% of the husbands said they had, 13% said they had not, and 9% said they didn't know.

Actual Instructions Given (P307, C307)

Of the providers, 36% said the first pill should be taken on day 5 or at the end of menses, while 24% said day one of menses. Another 27% said as per the packet instructions. There were noticeable differences by providers; about half of the Doctors and Health Practitioners said day 1 or day 5, but only one quarter of the Pharmacists answered the same way. Over half of the Pharmacists said "as per instructions" or "according to the brand."

Similarly, more than half of the users (63%) and almost half of the husbands (45%) said they were instructed to take the first pill on day 5 or on the last day of menses.

Couples Knowledge (C308)

Users and husbands were asked what they believed (as opposed to what instructions they had received.) Again, the most common response was day 5 or end of menses.

COMMENTS

While most respondents agreed that this instruction had been given at the time of first obtaining OCs, there appears to be several different ideas as to which day to begin the first packet.

The most commonly specified day was day five or end of menses. This does not agree with packet instructions or with the instructions given to SMP Medical Representatives and Sales Representatives. However, if the women did begin their OC careers on day 5 or on the last day of menses, they would still be protected. There are several possible explanations for this type of answer: (1) respondents really did believe this was the correct way to start, (2) respondents may have interpreted the question to be applying to continuing cycles rather than to the first cycle, and (3) the answers were complicated by the existence of different instructions for the different brands available in Bangladesh. Only 10% of the users gave answers which were quite incorrect under any of the above assumptions.

3.5 TIME OF DAY FOR TAKING THE PILL (Table 3.5)

All respondents were asked three questions about the time of day the OC should be taken, including whether instructions were given, the type of instructions given and attitudes about the importance of taking the pills at the same time of day, every day.

Whether Instructions Were Given (P316, C316)

All Doctors, 98% of Health Practitioners and 93% of Pharmacists said they had given instructions, at the time of the first sale, about the time of day the pill should be taken. Most users (92%) and husbands (80%) agreed; 8% of the husbands said they didn't know.

Type of Instructions Given (P317, C317)

Except for those respondents who did not know or who said that instructions had not been given, the vast majority said "bedtime." A minor exception was the Doctors group; 9% said "morning" and 7% said "any specified time of day."

Importance of Routine (P318, C318)

All respondents were asked if they thought it was important that a user takes the pill at the same time of day, every day. Virtually all answered positively.

COMMENTS

There was no noteworthy information from this series of questions other than that virtually all respondents seem to adhere to the idea of taking a pill every 24 hours.

3.6 INSTRUCTIONS ABOUT DAILY CONTINUATION (Table 3.6)

Three questions were asked of all respondents about continuing after the first pill was taken. The questions included whether such an instruction was given at the time of first purchase, what the type of instruction was, and their beliefs about daily continuation.

Whether the Instruction Was Given (P313, C313)

Of the providers, 96% of the Doctors, 94% of the HPs and 86% of the Pharmacists said they did instruct about this issue, while 85% of the users and 74% of their husbands agreed. Seven percent of the husbands said they didn't know.

Type of Instructions Given (P314, C314)

Of the providers, 63% said words to the effect that "one pill should be taken every day until the packet was used up." There were noteworthy differences by profession. Roughly the same proportions of users (70%) but fewer husbands (52%) said they had been told similar instructions. The only other instruction of consequence was "follow the arrow", offered by 20% of the providers, 13% of the users and 14% of their husbands.

Beliefs of the Rest of the Samples (P315, C316)

When those who said they had not given or taken instructions on this issue were asked about their belief, nearly all said "to take one pill daily, every day until the packet is finished."

COMMENTS

Virtually all users appear to know that a pill should be taken daily, and it is probably fair to infer that the most users know to take them in an orderly

manner.

3.7 INSTRUCTIONS ABOUT BEGINNING THE NEXT PACKET (Table 3.7)

All respondents were asked about instructions on the topic of when the next packet should be started. The pattern of questions was the same as above.

Whether Such Instructions Were Given (P319, C319)

Of the providers, 93% of the Doctors, 92% of the Health Practitioners and 79% of the Pharmacists said they did instruct on this topic when the first packet was prescribed or sold, while 85% of the users and 76% of the husbands responded similarly.

Type of Instructions Given (P321, C321)

Of the providers, 29% said "on the fifth menstrual day" or "after finishing the current packet", while 21% said "on the first menstrual day" and another 20% said "after finishing the current packet. There were considerable differences by provider because 24% of the Pharmacists said "on the first or fifth day of menstruation".

Half of the women (48%) and one-third of their husbands (34%) said either at the end of menstruation or on the fifth day. Another 15% of the users and 23% of the husbands said "after finishing the current packet." Only 5% of the users and 6% of the husbands gave other kinds of answers which indicated that they did not know the correct answer.

COMMENTS

This issue is complicated because different brands have slightly different regimens, and different respondents may relate their answers to different brands. This seemed to be the case here; a separate analysis showed a tendency for Ovostat users to answer this issue (C320) differently from Maya or Ovacon users (Ovostat has 22 contraceptive pills only, while the two SMP brands have 21 contraceptive tablets plus 7 iron tablets). But one type of answer stands out, namely, to begin the next packet on the first menstrual day. This is not the case with any brand, and yet a substantial proportion of providers, including 22% of the Doctors 25% of the Health Practitioners, and 14% of the Pharmacists gave that answer. Only a trivial proportion of users (4%) gave this answer, the majority indicating that they knew how to continue from packet to packet.

One explanation is that some respondents confused continuing packets with

3.8 INITIATING OCS AFTER CHILDBIRTH (Table 3.8)

Using the same questioning format, all respondents were asked about instructions for timing the start of oral contraception after a woman gives birth.

Whether Instructions Were Given (P327, C335)

Of the providers, 91% of the Doctors, 86% of the Health Practitioners, and 66% of the Pharmacists said they gave that kind of instruction. However, only 35% of the users and 43% of the husbands said they had been instructed on this topic.

Type of Instructions Given (P328, C336)

The most common answer was "at the next menses." Of the providers, nearly half (47%) gave this answer, including 59% of the Health Practitioners, 52% of the Pharmacists, and 31% of the Doctors. Other answers given by substantial proportions of providers were "40 days after birth" (15%) and "six months after birth" (9%). Of the Doctors, 27% said "40 days after birth" and another 18% said "six months after birth". For those users and husbands who said they had been instructed on this topic, nearly all replied "at the next menses".

Beliefs of Other Respondents (P329, C337)

When those respondents who said they had not given or received instructions on this topic were asked their beliefs, the most common answer was, again, "at the next menses." Of the users, 7% said "40 days after birth" and only 2% said "six months after birth", while 12% gave answers which were unusual, and less useful as a strategy for initiating oral contraception after childbirth.

COMMENTS

This is an important issue in a country like Bangladesh where breastfeeding is virtually universal and of very long duration. Contraception is redundant if initiated during the period of natural sterility which is provided by suckling. If oral contraceptives are used for a short period of time during this period the result could even be higher fertility than would have otherwise occurred.

The generally accepted strategy and policy in Bangladesh is to initiate OCs

Six months after birth, given the large ranges of duration of breastfeeding and of postpartum amenorrhea in the country, this strategy theoretically would result in a few pregnancies to those women who ovulated prior to six months, plus a considerable amount of redundancy for those women who initiated at six months but who were protected by suckling for several additional months.

Those few respondents who answered "six months after birth" are probably reflecting policy of the Bangladesh national program. Those who answered "next menses" may be providing a logical answer based on the OC manufacturers' policy of beginning OCs at the time of menses. The "forty days after birth" policy was probably offered because it fits the Islamic dictum of resuming sexual relations forty days after childbirth. If implemented generally in Bangladesh it would result in a large overlap between OC use and natural contraception afforded by breastfeeding.

Given the prolonged duration and the large variation in breastfeeding duration in Bangladesh, both the "6 month" and the "next menses" policies may result in roughly the same risk of pregnancy if applied universally. The "next menses" policy does have one additional benefit, however, namely, uniformity; it is the instruction given to new users by all manufacturers and programs, that is, to initiate OCs at the time of menstruation.

In Bangladesh, any initiation policy will be implemented after childbirth more often than not, given the nation's high fertility and the fact that very few women begin contraception prior to having a child. Thus, from the Bangladeshi users' perspective, the simplest and best policy is probably to always initiate OCs at the onset of menses. One additional benefit of this policy is the lower probability of inhibiting breastfeeding or passing contraceptive hormones to the breastfeeding child through the milk. This would be the case because the end of postpartum amenorrhea is associated with, and probably caused by, less frequent suckling. In other words, weaning and the return of menstruation both begin with less frequent suckling. Thus, initiating OC use when menstruation returns after childbirth should provide most women with effective contraception while minimizing the effects of inhibited lactation or passing OC hormones to the breastfeeding child. Under this policy a few women would become pregnant because ovulation usually precedes the return of menstruation, but this would also occur with a few who used the six month policy. Thus, all things considered, the "next menses" policy is probably efficient and effective.

3.9 INSTRUCTIONS ABOUT OTHER ASPECTS (Table 3.9)

A series of unstructured and structured questions was asked of all respondents about other instructions given at the time of first purchase.

Whether other instructions were offered (P322, C322)

Ninety-one percent of the Doctors, 86% of the Health Practitioners and 62% of the Pharmacists said they did offer additional advice, but only 20% of the users and 19% of their husbands answered similarly. An additional 3% of the users and 16% of the husbands said they did not know.

Types of Additional Information Offered and Received (P320, C320)

When asked what other types of advice were given at the time of first purchase, the following four topics were reported:

1. Possible nausea or dizziness. Warnings about this problem were reportedly given by 60% of the Doctors, 35% of the Health Practitioners and 31% of the Pharmacists. But only 4% of the users and 8% of their husbands responded similarly.

2. Possible changes in menstrual patterns. Warnings about this problem were reportedly given by 18% of the providers. But only 1% of the couples said they recalled receiving the information.

3. Instruction to take the OCs every day, routinely. This instruction was reportedly given by 22% of the providers. But only 3% of the users and 2% of their husbands said they had received the instructions.

4. Instruction to take two pills the following day if one day was missed. This instruction was reportedly given by 13% of the providers. But only 4% of the users and 2% of their husbands said they had received such instructions.

Probe on Remembering a Forgotten Pill (P324, C324)

Those respondents who did not spontaneously mention this topic were asked if it had been discussed at the time of first purchase. Eighty percent of the providers plus 77% of the users and 70% of the husbands said that it had. Nine percent of the husbands said they didn't know.

Type of Instructions Given (P325, C326)

Of those who responded positively to the above question, 41% percent of the providers and 49% of the couples said they had been told that two pills should be taken the next day if one day was missed. Much smaller proportions gave other answers, including take it when remembered, take it the next morning, and take it as soon as possible.

Those respondents who had not answered positively were asked what they believed should be done. They answered in approximately the same pattern as above.

Timing of the Instructions (C325)

The couples were asked when the instructions about forgetting were received; 65% of the users and 55% of the husbands said prior to using the first pack, while 12% and 13% respectively, said they learned later.

Probe About Side-effect Information (P330, C328)

Respondents who did not spontaneously mention this topic were asked if advice about side-effects had been given. A positive response was made by 89% of the providers and 43% of the couples.

Type of Side-effects Mentioned (P331, C329)

Of those respondents who said they had been told about side-effects, 87% of

the providers and 42% of the couples mentioned some kind of health side-effect. In addition, 32 % of the providers, 13% of the users and 9% of the husbands mentioned menstrual irregularities. Specific side-effects included nausea, dizziness, headache, weakness, and painful limbs. Many more were mentioned by trivial proportions of the respondents.

Timing of the Instructions (C330)

Thirty-six percent of the users and 34% of their husbands said they had been told about side-effects before first use, while 6% and 9% respectively, said they had been told later.

Probe About Instructions on Nausea/Dizziness (C331)

All users and husbands were asked if they had been told before first use about the possibility of nausea or dizziness before first use. Thirty-seven percent of the users and 41% of the husbands said yes.

Type of Advice Received (C332)

Those users and husbands who answered yes were asked what advice they were offered to deal with the problem. Seventeen percent of the users and 15% of the husbands said they were told to take special foods. A slightly smaller proportion said they were told to continue taking the pills, while trivial proportions said they were told to consult the doctor and/or to stop using OCs.

Probe About Warnings of Menstrual Changes (C333)

All users and husbands were asked if they had been warned before first use about possible menstrual changes. Thirty percent of the users and 25% of the husbands responded that they had.

Type of Advice Received (C334)

Those users and husbands who had answered affirmatively were asked what advice they were given about this problem. About half of the eligible respondents (16% of all users and 13% of all husbands) said they were told to continue. Trivial percentages reported they were told to consult the provider or doctor or to stop using OCs.

COMMENTS

The different proportions of providers and couples who reported positively on the above issues should not be compared too strictly because providers may be reporting their normal habits which don't necessarily apply to all couples. What is important is that couples are apparently not well -informed about all instructions and warnings about side effects.

Of equal importance is that providers appear to give warnings about side

effects which are not related to OCs, but very few other warnings about possible menstrual changes. This pattern of instruction could lead to unnecessary early discontinuation of OC use. Providers can cause unnecessary discontinuation if they only warn about possible side-effects, some of which, such as "weakness", are probably not caused by OC use. Providers should know that OCs actually cause very few side-effects and they should tell customers so, while telling them that if the user does experience nausea or dizziness, to continue with the OCs because the problem will probably go away.

On the other hand, providers may be causing unnecessary discontinuation by not warning clients about possible menstrual side-effects, particularly a decrease in menstrual flow. Several studies have shown that women who have not been told about this side-effect may become alarmed if they perceive oligomenorrhea and then may discontinue OC use; but if told to expect and welcome the benefits of less menstruation, there is a higher probability of continuation.

3.10 INTERPERSONAL COMMUNICATION ABOUT PROBLEMS (Table 3.10)

The users and husbands were asked a series of questions about types of OC issues they discussed with other people and who the other people were.

Communication Between Couples and Others (C338, C339, C340)

Only 27% of the users and 40% of the husbands said the user had ever had a question about OCs that needed answering. These users and husbands said they discussed such questions with their spouse, while fewer (13% of the users and 22% of the husbands) said they discussed the questions with other people.

Types of Other People (C341)

Users said they discussed OC topics with the following people, other than their spouses -- Family Planning Workers, 2%; doctors, 7%; relative, friends and neighbors, 4%. The users' husbands reported as follows -- Family Planning Workers, 7%; Doctors 13%.

Future Intentions (C342, C343)

When asked who they would discuss future OC questions with, 98% of users and husbands said "my spouse", while Family Planning Workers were mentioned by 17% and 21%; Doctors were mentioned by 38% and 69%; relatives and neighbors were mentioned by trivial proportions and "none" was answered by 30% of the users and 8% of the husbands.

Preferred Sources of Family Planning Advice (C318)

When asked whom they would seek family planning advice from, 41% of the users said "the doctor", as did 38% of the husbands. Another 10% of users and 17% of husbands said "government doctor", while another 14% of users and 15% of husbands said Family Planning Worker. Twenty-six percent of the users said "my husband." None of the users mentioned the Health Practitioner or Pharmacist,

although they were mentioned by 1% and 3% of the husbands, respectively.

COMMENTS

The low proportions of couples who said they had ever had a question may be a result of underreporting because these people are rather long-term users who may have forgotten earlier discussions. Thus the amount of communication between spouses and between couples and other people may also be higher than reported. On the other hand, this last finding might be partly explained by a cultural bias which leads respondents to give pleasing answers to such leading questions.

Of more importance is the emphasis reportedly placed by couples on husbands and "doctors" as sources of information. The emphasis placed on "doctors" by users and husbands should not be taken to mean only Doctors, in the sense of being a university graduate. In Bangladesh, the "doctor" could be a university graduate, a Health Practitioner, or even a Pharmacist. The importance of this finding is that spouses do communicate with each other and that providers, particularly those who are perceived as professionals, play a larger role than other possible channels such as mass media or relatives, friends and neighbors. Given the strong role of "family" in Bangladesh, it could be assumed that couples, particularly users, might turn to relatives in the same homestead for advice, but this avenue seems trivial. For SMP products information chain appears to be very similar to the product chain, namely from provider to husband to user.

Overall, findings from this Chapter suggest that users are not very knowledgeable about the pill before they begin. Ignorance about instructions and particularly about side effects can lead to early discontinuation. This problem points to the need for the SMP providers to educate their customers correctly about pill use. Given that face to face contact between providers and husbands is apparently the only commonly available one, it is imperative that providers not only know the basic instructions for taking pills but that they pass them along to customers. Of equal importance are the warnings about possible nausea, dizziness and menstrual changes; these warnings can be handled easily and may make a big difference in continuity rates. Such warnings, if given properly, could make the difference between satisfied, well protected users and dissatisfied, unprotected users who discredit OCs. From a fertility control perspective it is more important for the SMP to keep new users on the pill than to find new short-term users.

Lastly, one important issue which may be implemented differently and arbitrarily by different respondents concerned the timing of initiation of oral contraception after birth. The SMP management should consider standardizing instructions, probably in concert with other programs in Bangladesh, to direct users and potential users to initiate immediately upon return of menses after birth.

Chapter 4

PATTERNS OF USE

This Chapter addresses the following research objectives:

- To identify and describe patterns of OC use among SMP customers,
- To identify and describe perceived problems of OC use,
- To identify and describe reasons for dissatisfaction about, and discontinuation of OCs.

The format of this Chapter is similar to others; where possible, similar questions were asked of all respondents. But for some areas of enquiry only providers or couples or users were asked to provide information. When couple data were examined by provider group there were very few noteworthy differences, therefore most findings are reported for the entire user sample and for the entire husband sample without further breakdown.

Topics include duration of use, continuity of use, status of OC packets in the household, reasons for discontinuing, perceptions of contraindications, problems of taking OCs, and actions of discontinuers.

4.1 DURATION AND CONTINUATION OF USE (Table 4.1)

A series of questions was asked of users and husbands about how long ago use began, how long it continued, and the reasons for discontinuing.

Duration of Time Since First Use (C424)

As noted in Chapter 2 there was a very large range of duration of use -- from less than one year to twenty years. Using the users responses the mean duration since first use was slightly over four years. Using the husbands' responses, mean duration was slightly longer.

Continuity of Use (C425)

Users and husbands reported almost identically -- half of the users had continued since the time of first acceptance.

Duration of First Use (C426)

Those who discontinued after first acceptance used pills for a mean duration of 24 months before stopping. There was a noticeable difference by type of provider: Doctors' customers had a mean first segment of 8 months, Health Practitioners' customers 17 months, and Pharmacists' customers 36 months.

Reasons for Discontinuing (C427)

The several reasons for discontinuing given by users who discontinued can be classified under three rubrics: pregnancy, side effects and others. Approximately one third of the discontinuers fit into each category. For those who quit because of pregnancy, it is not clear which came first- the pregnancy or the quitting, therefore it cannot be concluded whether the users quit because they wished to conceive or whether they quit because they had conceived. Those who quit for health reasons cited a range of side effects including nausea and menstrual irregularities. Those who quit for other reasons cited temporary separation from their spouses, menstrual changes or to switch methods.

Beginning Again (C428)

Of those who quit the first time, all except 4% (who should not be classified as current users) began again.

Second Segment of Use and Continuity (C429, C430, C431)

Two out of three users who began a second time said they continued up to the time of the survey.

Repeated Stopping and Starting (C433, C434, C435)

Of the few (15%) who discontinued a second time, half stopped again. Thus, roughly one out of eight of the entire sample had restarted three or more times.

COMMENTS

As with most samples of current users, several patterns of past use have emerged. On the whole, our sample is of apparently satisfied users, not only because most could be called longterm users but because most who have stopped have begun again.

4.2 THE FUTURE (Table 4.2)

Additional questions were asked about current use which led to questions about future intentions.

Current Use and Future Intentions (C440, C441)

Ninety-three percent of the users said they were using pills at the moment. Husbands reported similarly. When asked about intentions to continue in the future only 3% of the sample said no, while another 10% was uncertain.

Rationale for Future Intentions (C442)

About two out of three users (64%) said their reason for continuing in the future was because they "want no more children" and can thus be classified as 'terminators'. A much smaller proportion (15% of the entire sample) said they wanted to delay a pregnancy, and can thus be classified as 'spacers'.

Of the 13% who said they would not continue in the future or were not sure whether they would continue, two reasons were given: they either said they preferred another method, or that OCs were injurious.

COMMENTS

One important finding that can be inferred from these results is high motivation; apparently the vast majority intend to continue practising contraception. The one negative aspect reported by one out ten users was related to objections to the pill, not to family planning. Thus, virtually all users (and husbands) reportedly will continue contracepting while nine out of ten will continue to use the pill.

A second important finding is the reason most often given for contracepting, namely, to terminate fertility. Several studies have shown that terminators are more successful contraceptors than spacers.

4.3 STATUS OF HOUSEHOLD SUPPLIES (Table 4.3)

Interviewers examined pill packets during the interview by asking users to show her the packet. Three types of information were sought: whether there

was a packet in the house, reasons for not having a packet, and status of existing packets. Findings are reported only for users as a group because there were no noticeable differences by provider type. Husbands were not asked this series of questions.

Supplies in the household (C443)

Five out of six (83%) users said there was a packet in the house while 16% said there was not, and 1% said they didn't know.

Status of the Packet (C445)

Packet status was classified in four ways, based upon the following findings: full (3%), empty (11%), partly full and correctly used (67%), partly full but not correctly used (2%). The remaining 17% did not show a packet to the interviewer.

Reasons for Not Showing a Packet (C444)

Of those who did not show a packet, more than half said the packet was finished, and almost all the others said they were menstruating, implying that they did not need any pills at the moment.

COMMENTS

The status of partial packets is an indicator of effective use. Of the entire sample, only 2% had packets which were improperly used, that is, pills were not taken out in accordance with the manufacturers' instructions. On the other hand it was not possible to know about the status of the pills of the 17% who could not show a packet for inspection. The users seemed well enough supplied with pills, given that a major brand (Ovostat, is supposed to be taken only 22 days out of 28, thereby leaving a six day interval when it would be quite normal to find no pills in the household.

4.4 USERS' COMPLIANCE POLICIES (Table 4.4)

Users were asked about their intentions to take pills routinely, that is, in compliance with manufacturers' instructions. Again, there were no noteworthy differences by provider type; consequently the results are shown for the users' sample as a whole.

Using Pills While the Husband Was Away From Home (C448)

The vast majority (94%) said they intended to take pills continuously, even if

Intention to Take One or More Pills Daily (C449)

Virtually all women (99%) said their intention was to always take one pill per day, neither more nor less.

COMMENTS

The problem of stopping while husbands are away is evident here, although not in a large percent of the sample. It is often mentioned as a program problem in Bangladesh, whether or not it may decrease effectiveness. It may change menstrual patterns, a phenomenon which may be acceptable to continuing users.

The stated intention to always take one tablet daily is reassuring since anecdotes are sometimes heard about several tablets being taken at one time. These users definitely know that one pill should be taken daily and they apparently intend to take pills in accordance with that regimen.

4.5 PERCEIVED CONTRAINDICATIONS (Table 4.5)

Providers were asked three questions about contraindications, namely, whether certain women should not use OCs, which types of women should not use them, and whether breastfeeding was perceived as a contraindication.

Whether Providers Believe All Women Can Use OCs (P419)

Not all women can take OCs safely, according to most (86%) of the providers, including 96% of the Doctors, 90% of the Health Practitioners and 65% of the Pharmacists.

Perceived Contraindications (P420)

Providers offered a long list of contraindications for OCs. The most commonly named problems were hypertension (36%), cancer (24%), ulcer (22%), diabetes (22%), and anemia (17%). Doctors named all of the problems, except ulcers, more frequently than the other two types of providers. Breastfeeding was not mentioned as a contraindication.

Perceptions of Breastfeeding as a Contraindication (P421)

All providers were asked if they considered breastfeeding as a contraindication. Sixty-three percent said it was; 28% said it was not,

while 9% said they didn't know.

COMMENTS

While most providers knew that some women shouldn't take OCs, substantial proportions, particularly of Pharmacists, said they thought all women could take them safely. This finding suggests that providers need more education about who can use OCs safely.

The inclusion of ulcers, anemia and TB as contraindications by some Health Practitioners indicates that they have added some contraindications to the generally accepted ones.

It is interesting that breastfeeding was not spontaneously included as a contraindication, but was acknowledged by the majority of providers when probed. It is difficult to know what this means since providers were not asked to explain. Perhaps some were simply agreeing with a leading question, while others may have heard that OCs appear to inhibit breastfeeding, particularly if used before lactation is fully established. Breastfeeding is not usually included as a contraindication of OCs even though the volume of milk might be slightly decreased in some cases, and very small quantities of hormones in the OCs could possibly be found in the milk or passed to the suckling child.

In general, there seem to be misconceptions and ignorance about contraindications among some of the providers. Future detailing of providers should include information about the true, small number of contraindications; this should be combined with an effort to inform providers that anemia, rather than being a contraindication, can be reduced by continued OC use.

4.6 REASONS FOR DISCONTINUATION (Table 4.6)

Providers were asked three questions about why some women discontinued OCs. Two of the questions probed pregnancy as a reason for quitting.

Reasons for Discontinuation (P425)

The overwhelmingly common answer was health problems; about three out of four of the providers (77%) said that when a woman stopped it was probably for health reasons. Only 15% said they thought it was for reasons of menstrual irregularity, while an even smaller proportion (11%) said it was because the women put on weight. Doctors particularly put emphasis on health problems.

Pregnancy Among Pill Users (P426, P427)

About one out of four providers (26%) said that they knew of at least one

of, about half of the 26% said "two".

COMMENTS

Health problems have again surfaced as the most important perceived pill problems, this time from the providers' perspective.

Pregnancy was apparently a minor, or unthought of reason among providers. When probed, they did say that it had occurred. It should not be assumed that the pregnancies were either planned or unplanned.

4.7 PROVIDER REFERRALS OF OC USERS (Table 4.7)

Providers were asked three questions about problems of OC use which might require referral of the user to another person or institution.

Occurrence of Referrable Problems (P422)

About one out of four providers (27%) said at least one couple had reported a problem which the provider thought needed referral. There was a noticeable difference between providers: only 16% of the Doctors reported such problems while 31% of the Health Practitioners and 38% of the Pharmacists reported such problems.

Types of Problems Reported (P423)

Roughly half of the providers who said they had discussed referrable problems said that health problems, including hypertension, nausea, dizziness and mental illness, were the most common. Almost as many reported menstrual changes.

Responses of Providers (P424)

The provider's response depended on the type of provider. Doctors tended strongly to refer patients to a Medical Specialist or to a Hospital, while Health Practitioners referred mostly to clinics and Pharmacists to a doctor.

COMMENTS

The responses of different types of providers were predictable; there was apparent referral to a higher level of the health services that was available and associated with the type of provider. For example, Health Practitioners are not generally associated with hospitals and would thus refer to lower levels, such as clinics, while Doctors generally have closer ties with hospitals and would refer problems there.

4.8 ACTIONS OF DISCONTINUERS (TABLE 4.8)

Providers, users and husbands were asked about the contracepting behavior of discontinuers. Two questions were asked: whether discontinuers switch and if so, what method they switch to.

The occurrence of switching (P428, C437)

Approximately two out of three providers said that OC discontinuers did switch to another method.

The same concept was put differently to the couples. Those who had ever discontinued were asked about their behavior. While this was a small number, it was apparent that most continued contracepting; for every one who stopped contracepting completely, three others said they switched to another method.

Next Methods (P429, C438)

Condoms were by far the most common answer for all providers, users and users' husbands. A substantial number of Doctors mentioned IUDs while a few Health Practitioners and Pharmacists mentioned spermicides.

Among couples, the number of discontinuers was very small, but of those who had discontinued, most mentioned condoms as their next method.

COMMENTS

Perhaps some providers might be overreporting in favor of condoms because they connect the interviewers with SMP products. But this bias probably did not operate with the users. Thus, condoms appear as a real alternatives for

This finding is beneficial from a program perspective and from a demographic perspective. We can infer that those OC users who purchase their supplies from the commercial sector are also users of condoms, should they stop using OCs. Demographically, the reportedly high incidence of switching, compared to stopping, means continuity of contraception, if not OC use.

It may be valuable for the SMP to know that discontinuers of OCs often move to condoms, since the SMP is the major distributor of condoms in Bangladesh. Perhaps users of one method which is made readily available by the commercial sector tend to use the commercial sector as providers of their next method.

4.9 Problems of Users (Table 4.9)

All respondents were asked about problems of oral contraception. Questions included the occurrence of problems, their types, and responses to them.

Problems Reported (P403) and Perceived (C405)

Providers were asked if a client or customer had ever reported a problem. Users and husbands were asked if they had ever had one or more problems. Of the providers 72% said they had received complaints, while 57% of the users and 68% of the husbands said that the user had had at least one problem.

Types of Problems (P404, C406)

Dizziness was the most commonly reported problem; it was mentioned by 29% of the providers, 39% of the users and 46% of the husbands. Nausea or vomiting were mentioned a little less frequently -- by 24% of the providers, 22% of users and 22% of husbands. A wide array of other health problems, including weakness and headache, was mentioned by 15% of the providers, 27% of the users and 42% of the husbands. Interestingly, more of the Pharmacists mentioned these health problems than did the other two types of providers. The reporting pattern for menstrual irregularities was quite different; they were reported by 40% of the Doctors, 24% of the Health Practitioners and 14% of the Pharmacists. They were also reported by 20% of the users and husbands.

Additional Problems (P406 & 407, C408 & 409)

When providers were asked if an other problems had been reported, 42% of the Doctors, 30% of the Health Practitioners and 17% of the Pharmacists said yes. Only 9% of the users and 15% of the husbands said that additional types of problems had occurred. The pattern of problems was similar to the one described above, namely a large range of different types of health problems plus mention of some menstrual irregularities.

Actions Suggested and Taken (P405, C407)

For all of the above problems, the actions suggested by providers and the actions undertaken by users were reported as follows:

- Continue OCs -- 39% of the providers, 23% of the users and 21% of the husbands,
- Take medicine -- 13% of the providers, 11% of the users, and 14% of the husbands,
- Consult doctor -- 17% of the providers (mostly Pharmacists), 8% of the users and 10% of the husbands,
- Switch method -- 10% of the providers (mostly Doctors), but none of the users and only 1% of the husbands,
- Stop OCs -- 5% of the providers, 5% of the users and 3% of the husbands.

COMMENTS

This is an important market research area because it concerns continuation. The results show that users associate health and menstrual problems with their OCs. The most prevalent problems were vomiting and dizziness, two related problems that can, in fact, be caused by OC use.

Of the providers, more Pharmacists reported problems. This was probably because Pharmacists had many more OC customers than the other providers. It may also be related to the large volume of Ovostat, a full-dose brand, sold by Pharmacists.

The consulting with "doctors" reported by users and husbands may need more interpretation. In Bangladesh the term often refers to qualified Doctors, Health Practitioners and even Pharmacists. Many users may not know the true qualifications of their OC provider or of local "doctors."

The reporting of "taking medicine" in response to the problems is another useful finding. An anti-nauseant medication, for example, would probably help users get over the most common complaints. Also, the psychological benefits of knowing that something is being done, should be beneficial. The combination of tangible and intangible benefits suggests a marketing opportunity that, if implemented, could produce a significant increase in the all-important continuity factor.

4.10 USERS' PERCEPTIONS OF HEALTH CHANGES (Table 4.10)

Only the users were asked about perceived changes in their health as a result

change and communication with others about the change.

Occurrence of Changes (C450, C451)

Almost exactly half of the users said they had noticed changes in themselves which they attributed to OCs. Most of the changes were health changes but, interestingly, two-thirds of those who reported health changes (34% of the sample) said the changes were beneficial. The other one-third (15% of the sample) said the changes were deleterious. Five percent of the sample also reported menstrual changes.

Continuation After Noticing Changes (C452)

Forty-five percent said they continued using OCs after noticing changes while 5% said they discontinued. As noted, the other 50% did not notice changes.

Communication About the Changes (C453 C454)

Two out of three of those who did discover changes said they discussed the changes with someone -- usually their husband. There were noticeable differences by type of provider; a user who had been identified by a Doctor was more likely to say she had discussed the changes with a Doctor, while a user who had been identified by a Pharmacist was more likely to say she had discussed the changes with her husband.

COMMENTS

From these results it appears that quite a few users experience problems which may lead them to discontinue temporarily or to simply continue until the symptoms diminish or disappear. It is particularly interesting that substantial numbers report beneficial changes. Users who experience beneficial changes should make very satisfied customers and promoters of oral contraception. If these changes could be specified they would probably make useful promotional material for the SMP.

4.11 PROBES FOR THE EXTENT OF NAUSEA (Table 4.11)

Those respondents who had not spontaneously mentioned nausea, vomiting or dizziness earlier, were asked if such conditions had ever been reported or experienced. Questions were also asked about users' responses to the problem and about the role of medicine to treat the problem.

Reported Levels of Nausea, Vomiting & Dizziness (P412, C417)

When the answers to spontaneous and probed questions were combined and analysed, the following pattern emerged: 72% of the providers said such conditions had been reported to them, at least once, while 43% of the users said they had experienced one or more of those problems.

Providers' Advice (P413)

Most of the providers who had been asked for advice on the problem reported that they usually suggested the users continue with the OCs; Doctors and Health Practitioners gave this advice more often than Pharmacists. Health Practitioners tended to offer medicine for the problem while Pharmacists did not. Pharmacists more often said they referred the customers to a Doctor.

Perceptions of Cause (C421)

When asked if they thought the OCs were the cause of the problem, virtually all users and husbands who had reported it said "yes."

Couples' Response (C418, C419)

Of the total sample, only 3% of the users and 6% of the husbands reported quitting because of the problem. Nineteen percent of users and of husbands reported that medicine had been used to treat the problem; this means that about two out of every five women who had experienced the problem used medicine to counteract it.

Perception of the Value of the Medicine (C421)

Of the couples who reported using medicine for the problem, virtually all reported that the medicine helped.

Perceived Market for Medicine (P415)

All providers were asked if they thought a medicine, if specific for nausea and vomiting caused by OCs, would be acceptable to their OC customers. Eighty percent said it would be acceptable, 8% said it would not, and 12% did not respond.

COMMENTS

These results show the importance of the dizziness cum nausea problem and the value of doing something about the problem. Whether the problems are caused by the pills is not the point; the point is that large proportions of users have experienced the problem and, as other studies have shown, perception of these side-effects can be a major cause of discontinuation.

These results also show that when medicine is used to counteract the symptoms, it appears to work to the satisfaction of the users. Providers tended to agree; only a small proportion seemed unenthusiastic about a medicine to

marketers to design a specific antinauseant product for OC users. These results show that such a product would probably be particularly acceptable to Health Practitioners.

4.12 PROBES FOR THE EXTENT OF MENSTRUAL CHANGES Table 4.12)

Using a similar strategy to the above probe into nausea, respondents who had not mentioned decreased menstruation as a problem were asked specifically about its occurrence and the response.

Occurrence of Menstrual Changes (P416, C422)

Of the providers, 75% said that menstrual changes had been reported as a problem. Almost half of the users (44 %) reported similarly when this specific probe was asked.

Responses to the Changes (P417, C423)

Most providers, users and husbands gave a similar response -- to continue taking the OCs. Only trivial percentages of providers reported suggesting stopping. Sixteen percent of the Doctors, however, suggested switching brands. A noticeable proportion of Pharmacists (24%) said they suggested consulting a Doctor, while 26 % of the Health Practitioners suggested a medicine.

COMMENTS

Decreased menstruation does not represent a medical problem. In fact, for Bangladeshi women, most of whom are anemic, the decreased bleeding commonly caused by OC use represents a benefit (Fortney & Potts, 1984). A marketing answer to this problem might consist of two responses: (1) making providers and consumers aware of the possibility of menstrual changes, particularly oligomenorrhea, resulting from OC use, and (2) promoting decreased menstruation as a real benefit of OC use. There is little value in offering or recommending a medicine to counteract the oligomenorrhea.

4.13 FORGETTING TO TAKE PILLS (Table 4.13)

Providers were asked two questions about clients who report forgetting pills. Users and husbands were asked a series of questions on the same topic.

Providers' Experience (P401, P402)

Seventy-four percent of the providers reported that at least one person had told them of forgetting to take a pill. But only 8% said they had received such reports often.

Users' Experience (C401, C402)

Sixty-two percent of the users and 56% of the husbands reported the user had ever taken more than one pill. But only 5% of the users and 2% of the husbands said it had occurred often.

Reasons for Taking More than One (C403)

Nearly all the users and husbands who had reported multiple pill-taking said it was done to "catch-up" on a forgotten pill.

Users' Response to Forgetting (C416)

Only 2% of the users and husbands said that the user quit taking OCs because she had forgotten to take one. Nearly all who had reported experiencing the problem, said the user had taken two pills as a response to forgetting a pill.

Highest Number Ever Taken on One Day (C404)

The majority of users who said that they had ever taken more than one, said that two was the highest number they had ever taken. Nine percent said they had taken three, while only 1% said they had taken more than three. Husbands' responses fitted the pattern but were slightly lower than the users'.

COMMENTS

Forgetting a pill and catching up by taking two is a common phenomenon among OC users. These users appear to fit in with that common pattern. Whether or not they forget more or less often than other users is uncertain, although it is known that compliance in rural Bangladesh is much less than perfect. In any event the SMP attempts to keep forgetting to a minimum by broadcasting the nightly reminder.

quit using OCs as a result of forgetting a pill, while most of the others apparently took two on the next day to "catch up" -- an acceptable procedure when only one day is missed. This pattern should continue to be promoted so that new users will continue. It is not known how many users discontinue because they forgot to take a pill.

Chapter 5

ATTITUDES OF USERS AND HUSBANDS

This chapter addresses the following research objective:

- To identify and describe users' perceptions of relationships between breastfeeding, menstruation and OC use.

Many studies have examined attitudes and beliefs about fertility and contraception in Bangladesh. Few, however, have dealt with the issue of attitudes about hormonal contraceptives, and particularly their use during lactation or postpartum amenorrhea. Contraception during lactation is an exceptionally important issue because breastfeeding duration is exceptionally long in Bangladesh. Thus, breastfeeding itself, has a powerful effect upon fertility and, as discussed in Chapter 3, it can interact with oral contraception. This study touched briefly upon users' and couples' beliefs about specific relationships which may have an effect upon their OC use patterns.

5.1 ATTITUDES AND BELIEFS (Table 5.1)

Spouses were asked two questions about OCs which plumbed their own feelings and their perceptions of their spouses' feelings.

Respondents' Attitude and Perception of Spouse's Attitude (C502, C501)

Using a five point scale, the users and husbands were asked how favorably they perceived OCs. Users appeared very well disposed -- 83% of them said they were strongly favorable. Husbands were almost as well disposed -- 67% said they were strongly favorable.

The proportions were about as high when respondents offered perceptions of their spouses' attitudes. Eighty-two percent of the users said they thought their spouse was strongly favorable, while 63% of the husbands said the same thing.

When "strongly favorable" and "quite favorable" were summed, the total was over 90% for all four answers.

COMMENTS

These very high ratings suggest a reason for the continuity of these users, namely, that they are satisfied customers. In their minds the benefits outweigh the disadvantages of the method.

5.2 BREASTFEEDING AND CONTRACEPTION (Table 5.2)

Users and husbands were asked several questions about the cause of postpartum amenorrhea, risk of pregnancy during breastfeeding, effects of OCs on breastfeeding, and perceptions of the effects of OCs on menstruation.

The Cause of Postpartum Amenorrhea (C503)

In answer to an unstructured question about the cause of the delay of return of menses after birth 89% of the users and 79% of the husbands responded that they did not know. The only other answer given by substantial proportions was "because of heavy bleeding during birth"; this answer was given by 7% of the users and 12% of the husbands. Only trivial proportions answered correctly -- "breastfeeding."

Risk of Pregnancy During Postpartum Amenorrhea (C504)

When asked if a non-contracepting woman could conceive before menstruation returned after a birth 80% of the users said yes as did 42% of the husbands. Another 15% of the husband said they did not know.

Risk of Pregnancy During Breastfeeding (C505)

Answers were more definite to this question; while small proportions said they did not know, 91% of the wives and 76% of the husbands said that pregnancy was possible during breastfeeding.

Effects of OCs on Breastfeeding (C506, C507)

When asked whether OCs affect breastfeeding, 63% of the users and 43% of the husbands said it did. Twenty-seven percent of the users and 37% of the husbands said it did not. The remainder said they didn't know. Of those who said that OCs affected breastfeeding, virtually all responded that the effect was to reduce or inhibit or dry up breastmilk.

Effects of Steroid Contraceptives on Menstruation)

On the basis of a three-point scale, four out of five women (79%) and almost as many husbands, answered that it was bad or harmful when OC use diminished or stopped menstruation. A trivial proportion said it was good.

COMMENTS

These findings illustrate that most couples probably do not understand that breastfeeding prevents or delays the return of menstruation. But they do know that pregnancy can occur before the return of menstruation and, similarly, that pregnancy can occur during breastfeeding. As might be expected, the wives were more knowledgeable than the husbands about these relationships.

More wives knew about the possible effects of OCs on breastfeeding, also. Lastly, they knew about the possible effects of OCs on menstruation and did not like the effects.

These results have an implication for program policy about initiation of contraception after birth and about educating potential users on the benefits of reduced menstruation. Firstly, if the SMP implemented a policy of initiating OCs when suckling frequency diminished or when weaning began it appears there would be little in the Bangladeshi belief system to prevent such a policy from being successfully implemented. Secondly, women believe that normal menstrual flow is more acceptable and welcome than reduced flow. Since OCs inherently reduce menstruation it is important that potential users and new users are told of this possible side effect, including the benefits, such as reduced loss of iron.

Chapter 6

PAST USERS

The information about users and husbands provided in the first five chapters was based upon data collected from couples identified as current users. The same types of data were also collected on a sample of 100 past users by interviewing couples who were identified as past users by current users and their husbands. The data collected from the sample of past users and their husbands was then compared for each question with the data collected from current users and husbands. The results are described separately, in this chapter for reasons of clarity and because there were very few differences between the two groups. It would have been very cumbersome to compare answers of current and past users and husbands in earlier chapters. The few important differences found in the analysis are tabulated in Table 6.1. This discussion focuses on those differences and on a few important similarities between the two groups.

Compared with the current users, past users might be expected to have had: more children, lower education, more dependence on husbands as purchasers, less access to supplies, longer travel times, less understanding of instructions, and more side effects. They might also be expected to have a less favorable attitude toward OCs. Findings on these and other variables are discussed next, using a format which similar to the format used in Chapters 1 to 5.

Demographic, Social and Economic Comparisons

The two groups were almost exactly the same. Demographics, such as numbers of living children were very similar. The past users and their husbands had slightly less education but the difference seemed hardly meaningful.

Purchasing Patterns

There were no noteworthy differences by usual obtainer, usual provider, difficulty of travel to obtain supplies, or perceived availability of supplies. The last two findings were unexpected because use has been related to availability in other studies.

Instructors and Instructions

The types of instructors and patterns of instruction for past and current users were about the same. Only one of the many factors stood out slightly from the others; husbands of past users had more difficulty than husbands of current users in correctly identifying the first pill in the package. This may have been related to lower education, but the sample size was too small to produce meaningful inferences.

expected, duration of the first segment of use was shorter for the past users, and far fewer began again after quitting the first time.

Of the many factors examined which may have influenced the past users to discontinue, only one stood out sharply -- health problems. This fact showed up in several ways.

Importantly, however, most past users took up another method at about the same rate as those current users who stopped using OCs from time to time.

Attitudes

As expected, the past users and their husbands had a less favorable attitude toward OCs, although this was less pronounced than expected.

COMMENTS

There are at least two useful findings from the comparison of past users and current users, namely the cause of discontinuation and the response to it.

Unquestionably, the major reason for discontinuation is perceived side-effects. Other factors, such as type of provider, availability and price seem not to be associated with discontinuation. Of all the side-effects examined here, the major reported problem was dizziness/ nausea/ vomiting, which is probably a syndrome of the three related symptoms. In some cases the problem may be psychological rather than real, but there is enough evidence here to support findings from many other studies that some OCs actually do cause these side-effects. Perhaps the incidence of dizziness, nausea and vomiting are quite noticeable in Bangladesh because many users have low body weight. One answer to the problem is to use the lowest possible dose consistent with effectiveness without breakthrough bleeding.

The finding that most discontinuers switch to another method is a happy finding from a fertility control perspective because it implies that most discontinuers motivation to contracept is not dulled by the bad experience of being sick from taking OCs. Unfortunately, such incidents tend to discredit OCs and make future marketing more difficult.

Chapter 7

TWO MORE USEFUL PERSPECTIVES

This chapter describes two additional analyses of the data which provided information which may be particularly useful to the SMP; these are from the perspectives of the usual provider and the residence of the users.

The research design used in this study has been very profitable. A wealth of information has flowed from the providers, users and husbands. However, one aspect has not given particularly useful information, that is, information about subsamples of users (or husbands) according to the type of provider who identified them. Only on a few occasions were meaningful differences found between the users or husbands based upon the type of provider who identified them. The analysis showed that this was caused by an incomplete attachment of the user-couples to the provider who identified them. In other words, a given user-couple was not necessarily a customer of the provider who identified the couple. In some cases the provider may have named the user-couple only because he knew that they used OCs, while another type of provider may have been the first provider and/or the usual provider. Thus, other perspectives were sought which could give further useful insights. The most promising additional perspective appears to be that of the usual provider; for example, it offered a better examination of the substantial number of users who obtained supplies from Family Planning Workers.

The second useful perspective was that of residence, namely urban vs. rural users. While the sampling design used urban vs. rural strata, the results were not reported by residence because of the complexity of adding another level to an already complex design which included three types of providers plus users plus husbands. But residence is a useful analytical perspective because it is often associated with different social, economic and marketing characteristics. Thus, it was used as an additional perspective and a summary of the results are given here.

7.1 THE USUAL PROVIDER (Table 7.1)

As reported in Chapter 2, all couples were asked to identify their usual OC provider. Of all the information which flowed from this perspective, ten points are noteworthy and are reported here under the usual headings of Social & Economic Characteristics, Purchasing Patterns, Instructors and Instructions and Patterns of Use. Generally, the differences found using this framework were sharper than those found using the original framework.

Education. There were noticeable differences on two measures of education, namely, whether school had ever been attended and the highest level completed. Pharmacy customers (those who said they usually obtained their OCs from a pharmacy) had more education than users as a group, while clients of Family Planning Workers and Clinics had less.

Husband's Occupation. More clients of Doctors and Pharmacists had service or government employment than the group as a whole, while the government providers served larger percentages of agriculturists. The Health Practitioners had a mixed clientele.

Purchasing Patterns

Usual Obtainers. There were sharp differences between the customers of commercial sector providers and customers of government services, as expected. Husbands predominated as purchasers from the three commercial providers while the users of Noriday often dealt directly with Family Planning Workers and clinics.

Preferred Brands. Pharmacy customers had a stronger preference for Ovostat, while clients of Doctors and Health Practitioners had preferences for a variety of brands.

Overlap of Household Supplies. More clients of Family Planning Workers and Clinics tended to have another packet in the house than did clients of the three commercial sector providers.

First Provider. There was a strong tendency for the first type of provider to be the usual type of provider. This picture was dominated by the pharmacy; while half of all the couples said their usual provider was a Pharmacist, fully 80% of those who usually purchased from a Pharmacist also reported that their first purchase was from a Pharmacy.

Instructors and Instructions

Best Instructors. The users who usually obtained supplies from Family Planning Workers said the workers had supplied most of the instructions. Users whose supplies were usually obtained from the three commercial sector providers said their husbands were the source of most instructions. A large proportion of husbands said that Doctors were the source of most instructions.

Intersperse Communication. Clients of Health Practitioners appeared to have more communication between the husband and wife.

Identification of First Pill in the Packet. Among users there were no noteworthy differences. However, among husbands, customers of Pharmacies were a little better than husbands as a group.

Use Patterns

Health Problems. Reported prevalence of health problems did not vary much by type of usual provider. Only one difference maybe useful although it is based on a small sample size; according to husbands who usually bought from Health Practitioners, their wives had fewer side-effects than the group average. This difference was not evident in the users' responses.

COMMENTS

Of the several useful marketing points described above, three deserve comment. They should help strengthen new marketing plans.

Firstly, the sharp differences between the government system and the SMP system. The government system has the advantage of using a woman to woman contact, where the user is instructed and served directly by a female provider. The SMP system is a man to man contact, where the husband intervenes and removes the user from communicating with the provider. Thus, the SMP must concentrate on instructing husbands on the correct manner of using OCs.

Secondly, the predominance of Pharmacists as providers of OCs. While about half of all couples reported that a Pharmacy was the usual provider, fully 80% of those who usually bought from a Pharmacy also reported that their first package was bought from a pharmacy. Many of these couples who are apparently loyal pharmacy customers had been identified by Doctors or Health Practitioners. The importance of Pharmacies as providers of SMP OCs is not new information; Pharmacists have always had much higher sales than other SMP providers. The importance of this finding is connected with the next finding, namely, different instructors of users.

Thirdly, the instructors. There are two major patterns. Women who usually obtain OCs from Family Planning Workers or clinics obtain instructions directly from the same source. Women who use commercial sources have no direct contact with the system and depend upon their husbands, who report that they obtain their information from Doctors or Health Practitioners. Pharmacists don't appear in this communication pattern. Thus, while Pharmacists are exceptionally important as providers of pills they are not important as instructors.

7.2 URBAN AND RURAL RESIDENCE (Table 7.2)

As reported in Volume I the sampling design produced 45% urban residents and 55% rural residents. The urban oversampling was purposeful and flowed from the sampling fractions applied to the providers. Therefore, this section offers an examination of the two subsamples to clarify differences.

Of the many differences found in the data by urban or rural residence only twelve stand out for purposes of market planning. Some were expected, such as social and economic differences. Others are more subtle and are emphasized here. In general, they tend to emphasize points which were discussed earlier.

Education of Users and Husbands. Rural education levels were not much lower than urban levels, contrary to expectations. However, slightly larger proportions had not attended school.

husband's occupation. As expected, more husbands in the rural sector were employed in agriculture, but the differences were not great.

Purchasing Patterns

Number of Brands Ever Used. Rural residents reporting using fewer brands.

Brand Loyalty. Of those who had only used one brand, more rural Noriday users were loyal. Fewer rural residents preferred Maya, but more preferred Ovacon.

First Provider. Only a tiny number of rural couples (6%) obtained their first supplies from a Doctor, compared to 15% of urban couples. These proportions were reversed for Health Practitioners. Pharmacists still provided first packets to 38% of the rural couples and to 55% of urban couples. On the other hand, Family Planning Workers were major suppliers of first packets to rural couples (42%), but to fewer urban couples (24%).

Usual Provider. The proportions described above for first provider applied almost exactly to usual providers, also.

Travel Difficulties. Compared to urban respondents, more rural respondents said they had travel difficulties.

Overlapping Supplies. More rural users reported having additional supplies in the house. This was related to those couples who obtained from Family Planning Workers.

Instructors and Instructions

Best Instructor. Proportions were about the same between urban and rural samples, showing no great differences from the results reported in Chapter 3.

Use Patterns

Health Problems. Compared to urban women, fewer rural women reported having health problems.

Continued Without Stopping. More rural women continued first segment of use up to the time of the survey, whereas more urban women stopped and started again.

COMMENTS

There was nothing in the urban/rural analysis to refute or qualitatively

system and the Health Practitioners.

Compared to the urban picture, rural couples depend more upon the government Family Planning Workers, home delivery and Noriday. In rural areas the popularity of the SMP program appears to rely upon the Health Practitioners and Ovacon.

Conclusion

Information provided in this Chapter has emphasized firstly, the enormous role of Pharmacists as providers and their weak role as instructors. Secondly, the relative strength of the government system of women to women in the rural area, where Noriday is popular. Thirdly, the continuing importance of the husband as provider and instructor for users who prefer Maya, Ovacon or Ovostat. Policy implications and recommendations based on these and other findings are discussed next.

Chapter 8

POLICY IMPLICATIONS AND RECOMMENDATIONS

This Chapter brings the study findings together in a form suggested by the last research objective, namely:

- To synthesize the information into practical recommendations.

This chapter is not intended as a summary or a review; a short summary is available in Volume III. Instead it is intended to synthesize the findings into a few important areas which are amenable to market planning. The recommendations will be brief; managers in the field will be able to combine the many details from the preceding chapters with information from other sources to assist in formulating their detailed marketing plans.

Those SMP successes which began in 1981 required major changes in product, price and distribution activities along with a few changes in promotional activities. These four perspectives -- product, price, distribution and promotion -- will be used here as a framework to discuss policy implications and recommendations derived from the results of this study. Thus, the format of this chapter differs from those used in earlier chapters. This chapter deals with only two topics: a discussion of the SMP's progress to date in building an OC market in Bangladesh, and recommended strategies for expanding that market -- particularly the rural segment.

Emphasis will be placed on expanding the rural market for three reasons: (1) it is the largest and most underserved market in Bangladesh, (2) the SMP now has some experience with rural OC distribution through a few thousand rural Health Practitioners, and (3) SMP managers have stated a desire to expand the rural market for OCs.

8.1 PROGRESS TO DATE

Products

The two SMP products appear to be as acceptable to their loyal users as do Ovostat and Noriday to their loyal users. While there is some evidence in this study to indicate that Ovacon users may complain less about adverse side effects, a more important finding is that many current and past users of all four major formulations reported side effects, particularly dizziness cum nausea and menstrual changes. The SMP does not yet market a minipill (progestin without estrogen) or the new, promising tricyclic pill; these

with different patterns of side effects. The side effects may be more acceptable to those Bangladeshi women who become quite ill from nausea or alarmed by their menstrual changes caused by current formulations; tricyclics mimic natural hormonal fluctuations better than the compounds now used in Bangladesh.

A second aspect of product is packaging; Maya and Ovacon are always distributed with one cycle per packet. This may be a cause of the finding that relatively few households had additional supplies of commercial brands of OCs on hand. By contrast, users of government supplies more often have additional supplies on hand; this is probably due to obtaining more than one cycle at a time and to having home delivery by government Family Planning Workers.

A third aspect is related products, particularly for side effects amenable to medication. Dizziness and nausea can be ameliorated by antinauseant preparations; if made available through SMP channels such preparations could lead to larger numbers of healthier, satisfied users, less discrediting of OCs and an increase in the all-important continuity rate needed to increase birth intervals, lower fertility and improve maternal health.

But not all product side effects reported in this study were harmful. A substantial number of women reported improved health as a result of taking OCs. This happy result could possibly be used successfully in promoting OC products if it were well understood.

Price

Both SMP products retail for much less than the leading commercial brand, Ovostat. There was very little evidence in these findings to indicate that users were concerned about prices being too high; this suggests that one reason for Ovostat's continuing popularity may be its higher price, that is, a better image because of it costs more. The rapidly increasing sales of Ovacon, compared to Maya, may be another part of the same picture. Thus, SMP's strategy of pricing Ovacon four times higher than Maya was probably very sound, but the continuing popularity of Ovostat suggests that still higher prices might enlarge the market still further.

Distribution

Good distribution has probably been very important to SMP's success during the past four years, as OCs have moved out of general provisioners shops, and been concentrated more in the hands of the three types of providers studied here. As the SMP emphasizes the rural sector more, however, distribution will be forced away from Doctors and toward Health Practitioners and Pharmacists, because of the different numbers of each type of provider available in rural areas. In fact, Health Practitioners are much more plentiful than Pharmacists in rural areas.

Distribution of an antinauseant should fit well into a rural marketing campaign given the finding that Health Practitioners, in particular, appear keen to sell medicine for OC side effects.

Distribution through existing retailers is not the only marketing route, however; household delivery systems of OCs appear to work well in Bangladesh as in other Asian countries. There appears to be advantages in having a

through the government system, a Matlab type of system, or the successful system attempted by the SMP in a test area in 1980. While household sales may be more expensive than retailing, it is clearly not prohibitively expensive, given that it continues in Bangladesh today. Furthermore, there would probably be economies of scale if enlarged beyond test market size. The continuing face to face contact between a specially trained sales person and the user would probably result in greater knowledge, confidence and motivation for new users.

Promotion

It is well known that most couples in Bangladesh have heard of OCs and that the SMP has made the word Maya synonymous with oral contraception; and there was nothing in the findings of this study to suggest that SMP's advertising has been counterproductive in any way. However, this study has focussed on the factual side of promotion rather than the persuasive side to gain an understanding of what couples know and experience. And the findings suggest that some providers lack knowledge about some instructions. Furthermore, it appears the providers do not offer important advice about the two major side effects before the user begins her OC career. While Pharmacists currently sell the lion's share of OCs, they appear to be the least appropriate for providing instructions, warnings and follow-up advice because, by their own description, their main occupation is selling, not advising. Thus, the SMP must depend very heavily upon Rural Health Practitioners in the future, not only for distribution, but for providing adequate instruction, education, advice and for complementary products, such as antinauseants. Effective face to face communication between Rural Health Practitioners and husbands of users will probably be critical to future success in rural areas.

8.2 RECOMMENDATIONS

Based upon the above discussion of major policy implications which followed from the study, SMP managers may wish to consider the following recommendations.

Product

1. To add at least one more brand aimed at having the lowest level of side effects commensurate with safety and effectiveness. At least two possibilities exist; progestin only "minipills" and tricyclic "Triple 7" pills. Minipills generally have the advantage of not interfering with normal breastfeeding but are associated with breakthrough bleeding, and have slightly less effectiveness than pills containing both progestins and estrogens. Tricyclic pills contain the two usual hormones -- one estrogen and one progestin -- in three different formulations, one for the first seven days, one for the next seven days and one for the last seven days. This formulation comes close to duplicating the normal concentrations of the two hormones, and appears to result in fewer untoward side effects such as nausea and decreased

2. To design and pretest package inserts for the new brand(s) which reflect a unified educational policy for all SMP OCs. This aspect is also discussed below under "Promotion".

3. To test and redesign existing package inserts for Maya and Ovacon to parallel the insert for the new brand(s).

4. To test market an antinauseant medication suitable for use as a follow-up sale for OCs.

Price

1. To test market the new product(s) in a pricing niche slightly higher than Ovacon, and aimed at maximizing the quality image and thus acceptance.

Distribution

1. To continue to sell old and new brands of OCs and antinauseants into all three types of providers, as available in rural areas.

2. To design and implement a large scale subsidized expansion of the small test market of door to door selling implemented in 1980, which resulted in higher OC prevalence in the area.

Promotion

1. To reformulate OC promotion strategy and resource allocation, shifting away from brand awareness to promoting a fuller knowledge of the basic instructions and the two common side effects.

2. To develop a unified approach to promotion so that field personnel, providers, available mass media, packet inserts, Mobile Film Units and other channels will communicate the same basic messages.

3. To discontinue the policy of initiating use six months after birth of a child and replace it with a policy of initiating use immediately upon return of menses.

4. To concentrate on educating large numbers of rural Health Practitioners to become knowledgeable extensions of the SMP OC distribution and promotional system, emphasizing the need for Health Practitioners to educate patients, clients and husbands before providing the first packet.

5. To commit the Mobile Film Units to a larger educational role about oral contraception, including explicit instructions and advice about OC use, if possible.

Conclusion

Since modifying its strategy in 1980-81, the SMP has done a good job of expanding sales of OCs in Bangladesh. But if continued long term market expansion means increased rural penetration, then additional acceptable and beneficial products will be required. More importantly, continued long term expansion will require commitments of more resources to harnessing large numbers of rural providers who can not only sell an increasing number of SMP products to husbands of potential new users on a continuing basis, but who will also competently provide necessary instructions and advice as required.

To maximise the potential market, this interpersonal approach to motivating, instructing and advising both potential and continuing consumers should be a part of a unified approach to using all available media to educate the population about the pill and its use while motivating couples to obtain and use them for long periods of time. Only through continued use will a woman significantly decrease fertility while improving her health. These recommendations are aimed at reaching that long term goal.

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ORAL CONTRACEPTIVE MARKETING IN BANGLADESH

VOLUME III. EXECUTIVE SUMMARY

FINAL REPORT

Prepared for: Bangladesh Family Planning Social Marketing
Project and Population Services International.

Prepared by : J. Davies, Consultant, Honolulu

Supported by: Office of Population and Health, USAID Mission
to Bangladesh

Honolulu, December, 1984

ACKNOWLEDGEMENTS

The study is a joint effort of the Social Marketing Project management, USAID office of Population and Health/Bangladesh, Population Services International, Mitra and Associates, and John Davies, Family Planning Consultant. The authors wish to thank Mr. S. Anwar Ali, Mr. W.P.Schellstede and the management of the project for their continuing helpful participation. We are grateful also for the financial support of USAID and particularly wish to thank Mr. John Thomas and Dr. Carol Carpenter of the USAID Mission to Bangladesh for their helpful comments and technical suggestions during the planning stage. We hope that the results of the study will be a suitable reward for the efforts of all the participants.

John Davies, Principal Investigator

S.N. Mitra, Executive Director
Mitra and Associates

EXECUTIVE SUMMARY

This summary is intended as a short review. It is not intended to be complete, except for the Recommendations and Conclusions section, and therefore is probably not suitable for SMP operations managers. It contains the following three sections: Background, Results & Policy Implications, Recommendations & Conclusions,

BACKGROUND

This section summarizes the history of the study under three headings: Purpose & Benefits, Rationale and Method.

PURPOSE & BENEFITS

This market research was designed to assist the SMP managers to improve the marketing and the use patterns of their oral contraceptive (OC) products. Benefits should include: (1) improved market planning, leading to (2) increased OC sales, prevalence, effectiveness and duration of use, and (3) lower fertility and better health for users.

RATIONALE

Market strategy for OCs was changed in 1980, leading to greatly increased sales. But there is little information about the following: nature of the providers, users and purchasers; stocking and selling patterns; instructors and instructions; patterns of use and problems of users. The research is designed to provide that information.

METHOD

An area of Bangladesh in Rajshahi Division was purposefully chosen as the research site because it was deemed typical of SMP OC marketing. A random sample of 123 providers of SMP OCs was selected and interviewed. At the end of each interview the provider was asked to name his OC customers. These 365 couples were then located and interviewed; each husband and wife was interviewed simultaneously, but separately, using almost identical questionnaires. At the end of each interview respondents were asked to provide names of past users (those who had discontinued). These 100 couples, who provided a comparison group, were then located and interviewed in exactly the same way as current users.

All field work was undertaken by Mitra and Associates, an experienced survey research agency. It lasted from May 6 to June 17, 1984 and required four teams of interviewers plus one quality control team.

Data processing was undertaken in Bangladesh and consisted of hand tabulations for production of key tables and an Interim Report in Bangladesh, plus computer tapes for producing tables needed for the Final Report which was completed by the Principal Investigator at the University of Hawaii. The Interim Report was produced at the end of September, 1984. The Final Report was completed in December, 1984.

RESULTS AND POLICY IMPLICATIONS

This section provides highlights of some of the most important findings, particularly those which led to specific recommendations. SMP managers will find that many other findings, which are included only in Volume II, will also be very useful for market planning.

Findings are discussed in sections which reflect chapter titles in Volume II of the Final Report. Each section contains two parts: Findings and Policy Implications.

PROVIDERS, USERS AND HUSBANDS OF USERS

Findings. The three strata of providers, namely Doctors, Health Practitioners and Pharmacists, differed by education: Doctors had a medical degree, by definition, while Health Practitioners did not. All Health Practitioners and

Pharmacists were found to have a minimum of high school education. Doctors and Health Practitioners described their main occupation as advising patients rather than selling medication, while Pharmacists answered in the reverse manner.

Most users were young -- between the ages of 20 and 34 years. Most had two or three living children. Most users had attended school and about half had completed grade 6 or higher. Their husbands were better educated: more than half had at least completed high school. Most couples owned land and had a radio in the household. Most husbands were employed in business, government or agriculture. Those couples who were found through Pharmacies tended to have a better education and to be employed in business or government.

Policy implications. There are implications for literacy, fertility control and health. Social status of the providers, users and husbands is high, given their levels of education and occupations; this implies that most couples are literate enough to understand written OC advertising, instructions and warnings printed on packet inserts and fully understand how pills should be taken. They can also afford to buy OCs regularly and thus continue use. The youthfulness of users implies probable lower completed fertility and improved health.

SELLING AND PURCHASING PATTERNS

Findings. Nearly all providers stocked at least one of the SMP's two brands of OCs -- Maya and Ovacon. But Ovostat, a higher priced commercial brand, had higher sales volume than the SMP brands. Doctors sold very few OCs per month; Health Practitioners sold more, but Pharmacists sold more than the other two providers combined. Providers said that freedom from side effects was the most important factor in selecting a brand.

Providers who had identified the user couples were not always the first providers or the usual providers of OCs. Regardless of which provider identified them, most couples used Pharmacists and Family Planning Workers as their first providers and their usual providers, reflecting the national program pattern. In rural areas Family Planning Workers were major providers, as were Pharmacists.

The usual purchasers were husbands, not users. Exceptions were those users who obtained government supplies; they were often delivered to the user by a Family Planning Worker.

Couples said that availability was rarely a problem; for those who usually purchased from the commercial sector, most had a travelling time of less than ten minutes. But few had additional supplies in the house.

Policy implications. There are implications for marketing strategy, including conceptualizing husbands as important "providers" of OCs to the users. Secondly, for future expansion of rural distribution, where Pharmacists are far less common, the SMP must depend more on Health Practitioners than on Doctors and Pharmacists. Thirdly, the popularity of the home delivery system

suggests looking again at the door to door campaign tested by the SMP in 1980; such a system may increase the number of couples who have another cycle in the household when the current cycle is finished.

INSTRUCTORS AND INSTRUCTIONS

Findings. Most users received instructions from their husbands about how to use OCs; others received instructions from Family Planning Workers. The most important source of instructions for husbands was a "doctor", possibly a graduate Doctor or a Health Practitioner, since both are usually called "doctor" by laypeople. Pharmacists were not an important source of instructions.

Most providers, users and husbands understood the four instructions for taking OCs, namely to initiate use at menses, which pill to take first, to take one pill every 24 hours, and when to continue with the next cycle. However, there was a lack of clarity in the responses about when to continue the next cycle, but this was somewhat associated with brands: Ovostat has only 22 pills, compared to other brands which have 28. There were several understandings about when to begin OCs after birth; most answered "at the time of menstruation", which conflicts with SMP and national program policy of initiating six months after birth if breastfeeding (the majority breastfed).

Most providers said they gave additional instructions or warnings at the time of first purchase, such as "the pill may cause weakness". But few users or husbands said they had received any additional instructions or warnings; only a few knew in advance that common side effects such as nausea or menstrual changes may occur.

Policy implications. There are implications for educating providers. Providers who warn purchasers to expect "weakness", but not nausea or menstrual changes, are not helping users to succeed. If users are told about these two possibilities, including the fact that nausea subsides with continued use of OCs and that decreased menstruation is beneficial, they have a higher probability of continuing.

PATTERNS OF USE

Some users began their first segment of use less than one year before the survey, others began ten or more years before. The average was four years. About half had taken pills continuously since first use, the other half had stopped and started again at least once. The vast majority said they would continue because they wanted "no more children".

Examination of users' packets showed that only 2% were partially used and also had pills removed in the wrong sequence. The remainder either had a full packet, an empty packet, or no packet to show.

The most commonly reported problems associated with OC use were health problems, namely dizziness or nausea; many users had experienced them but had persisted in taking pills or stopped and begun use again. Another unwanted side effect was reduced menstruation. Most providers had also received complaints about the same two side effects; as a response, Health Practitioners tended to offer medication, while Pharmacists tended to refer customers to a doctor. Users said the medication helped. Importantly, though, many users cited the long term health benefits of OCs. Those who stopped temporarily often used another method, such as condoms.

Policy Implications. Again there are implications for educating providers because many users experience nausea and/or unwelcome menstrual changes.

There are also implications for products marketed by the SMP. Neither of the SMP OCs is a minipill (progestin only) or a tricyclic ("777"); Maya is a regular dose OC while Ovacon is a low dose. Tricyclics are said to be more acceptable to many women because they mimic the natural cycle more closely than other formulations. Secondly, the SMP does not market an antinauseant to counteract the major side effects of OCs. Thus, there appears to be two marketing opportunities here.

ATTITUDES OF USERS AND HUSBANDS

Findings. Most users said they were very satisfied with OCs. On the relationships between OCs and lactation, most believed they could conceive during lactation and/or before menses returned after childbirth. But very few knew that breastfeeding was the cause of delayed return of menses after childbirth. About half believed OCs reduced the quantity of breastmilk. Most said that reduction of menstruation by OCs was unwelcome.

Policy implications. Firstly, there are implications for initiating OC use after childbirth; the belief system would not seem to interfere with a policy to begin OCs at the time of reduced suckling (or weaning) or at first menses. Secondly, there is reinforcement of the implications for educating providers about the possibility of reduced menstruation and of its benefits.

PAST USERS

Data from past users and husbands were compared to data from the current users and husbands. They were very similar to current users and husbands in most ways: demographically, socially and economically, as well as in patterns of purchasing, instruction and use. But they differed in one important way -- unwelcome side effects. More past users complained of unwelcome side effects, particularly dizziness and nausea. Many who discontinued OCs did continue contracepting, however, often using condoms.

Policy implications. These findings reinforce two earlier ones: the need to educate providers to warn about and assist with nausea problems, and the advisability of using an additional formulation, such as tricyclic OCs.

RECOMMENDATIONS AND CONCLUSION

The recommendations are based upon the above findings and policy implications. They are offered in the context of management's declared objective of increasing the effective use of OCs, particularly in rural areas. The recommendations are described under the four standard marketing concepts of product, price, distribution and promotion.

RECOMMENDATIONS

Product

1. To add at least one more brand aimed at having the lowest level of side effects commensurate with safety and effectiveness. At least two possibilities exist; progestin only "minipills" and tricyclic "Triple 7" pills. Minipills generally have the advantage of not interfering with normal breastfeeding but are associated with breakthrough bleeding, and have slightly less effectiveness than pills containing both progestins and estrogens. Tricyclic pills contain the two usual hormones -- one estrogen and one progestin -- in three different formulations, one for the first seven days, one for the next seven days and one for the last seven days. This formulation comes close to duplicating the normal concentrations of the two hormones, and appears to result in fewer untoward side effects such as nausea and decreased menstruation.
2. To design and pretest package inserts for the new brand(s) which reflect a unified educational policy for all SMP OCs. This aspect is also discussed below under "Promotion".
3. To test and redesign existing package inserts for Maya and Ovacon to parallel the insert for the new brand(s).
4. To test market an antinauseant medication suitable for use as a follow-up sale for OCs.

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1. To test market the new product(s) in a pricing niche slightly higher than Ovacon, and aimed at maximizing the quality image and thus acceptance.

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1. To continue to sell old and new brands of OCs and antinauseants into all three types of providers, as available in rural areas.

2. To design and implement a large scale subsidized expansion of the small test market of door to door selling implemented in 1980, which resulted in higher OC prevalence in the area.

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1. To reformulate OC promotion strategy and resource allocation, shifting away from brand awareness to promoting a fuller knowledge of the basic instructions and the two common side effects.

2. To develop a unified approach to promotion so that field personnel, providers, available mass media, packet inserts, Mobile Film Units and other channels will communicate the same basic messages.

3. To discontinue the policy of initiating use six months after birth of a child and replace it with a policy of initiating use immediately upon return of menses.

4. To concentrate on educating large numbers of rural Health Practitioners to become knowledgeable extensions of the SMP OC distribution and promotional system, emphasizing the need for Health Practitioners to educate patients, clients and husbands before providing the first packet.

5. To commit the Mobile Film Units to a larger educational role about oral contraception, including explicit instructions and advice about OC use, if possible.

CONCLUSION

Since modifying its strategy in 1980-81, the SMP has done a good job of expanding sales of OCs in Bangladesh. But if continued long term market expansion means increased rural penetration, then additional acceptable and beneficial products will be required. More importantly, continued long term expansion will require commitments of more resources to harnessing large numbers of rural providers who can not only sell an increasing number of SMP

products to husbands of potential new users on a continuing basis, but who will also competently provide necessary instructions and advice as required.

To maximise the potential market, this interpersonal approach to motivating, instructing and advising both potential and continuing consumers should be a part of a unified approach to using all available media to educate the population about the pill and its use while motivating couples to obtain and use them for long periods of time. Only through continued use will a woman significantly decrease fertility while improving her health. These recommendations are aimed at reaching that long term goal.

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