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## Initial Acceptability of Contraceptive Implants in Four Developing Countries

**In Bangladesh and Nepal, women with no education were more interested in trying NORPLANT contraceptive implants than were women with some education, while in Haiti, women with the most education were most interested in NORPLANT.**

By Thomas T. Kane, Gaston Farr and Barbara Janowitz

### Summary

An analysis of 2,586 potential acceptors of hormonal contraceptive implants (NORPLANT®) interviewed at 10 family planning clinics in Bangladesh, Haiti, Nepal and Nigeria reveals that interest in trying NORPLANT is high: Between 48 percent and 67 percent of respondents who had come to the clinics to start contraception or to obtain information about NORPLANT and were considered potential implant acceptors expressed an interest in trying the method. Large proportions of women identified effectiveness, reversibility and convenience as the implants' most attractive aspects. Women in their late 20s or older who had had a few children and were interested in spacing births for at least several years or in limiting births, but were not ready for sterilization, were most likely to express interest in NORPLANT. The findings also point out the need for thorough counseling to reduce the apprehensions that women and their husbands may have about the method, such as fear of side effects or of the insertion or removal procedure.

### Introduction

The continuing search for more convenient, effective and culturally acceptable methods of contraception has led to the development in recent years of a series of

long-acting steroidal contraceptive methods. One of these is the subdermal hormonal implant system called NORPLANT, which is in the early phases of introduction in a number of developing countries. NORPLANT is a low-dose, progestin-only contraceptive tested in clinical or preintroduction trials involving over 55,000 women in 44 countries. As of January 1990, it had also been approved for programmatic use in at least 14 countries, where over 400,000 more women have used it.

NORPLANT works by allowing the steady release of low levels of levonorgestrel from six capsules implanted beneath the skin of the user's upper arm. Only a small incision is needed to insert or remove the implant. Within 24 hours of its placement in the arm, NORPLANT is releasing levonorgestrel at levels high enough to prevent pregnancy, and it continues to do so for more than five years. In the majority of menstrual cycles, the circulating level of levonorgestrel prevents ovulation; in the relatively rare cycles in which ovulation does occur, however, the implant prevents pregnancy by thickening the cervical mucus (and thus impeding sperm penetration) and by suppressing endometrial development. Users usually begin to ovulate and become capable of conceiving shortly after the capsules have been removed.<sup>1</sup>

During the past decade, an increasing body of research has focused on the introduction and acceptability of new contraceptive methods in various countries. A major objective of such research is to provide feedback to family planning program managers and biomedical researchers, to enable them to modify programs and technology accordingly.<sup>2</sup> Although preintroductory clinical trials have examined continuation rates and user satisfaction, questions remain about the potential popularity of the method among contraceptive users.

The success of any new method depends to a large extent on its acceptability. A user's initial reactions to a method will depend, in part, on what information the individual has received about the method and how that information has been presented. Numerous factors may affect a woman's interest in and decision to adopt a new method such as NORPLANT: These include the method's side effects, insertion and removal procedures, effectiveness, reversibility and contraindications, the woman's desire for more children, concerns about her fertility following use and correct knowledge of how the method works and her husband's attitude toward the method, as well as rumors about the method and religious considerations.

A previous publication has outlined the

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various types of attitudinal and behavioral studies of contraceptive acceptability and the value and limitations of each methodological approach.<sup>3</sup> To date, most studies of NORPLANT's acceptability have focused on acceptors' characteristics, attitudes, perceptions and degree of satisfaction, and on their rate of continuation or discontinuation.<sup>4</sup> However, with the exception of the clinic-based surveys reported in this article, very little has been done to look at the interest in or potential demand for NORPLANT among users most likely to be considering a new method—women seeking family planning services. Research on NORPLANT so far has generally failed to examine the earliest stage of contraceptive adoption—initial acceptability. This stage includes the family planning client's first exposure to information about the method, her subsequent interest or lack of interest in it and her decision whether or not to use it.

Our study attempts to determine the level of interest in trying NORPLANT among women visiting family planning clinics in Bangladesh, Haiti, Nepal and Nigeria. The objectives of the surveys that we conducted were to determine the impact of social and demographic factors on interest in contraceptive implants, to discover what women interested in the method liked about it and to learn what women not interested in the method disliked about it. Such findings may help family planning program administrators and service providers identify potential NORPLANT acceptors, as well as enable providers to develop programs that can help overcome some of the obstacles to acceptance.

### **Methodology**

As part of the recruitment for NORPLANT preintroductory clinical trials in 1985 and 1986, NORPLANT Acceptability Surveys were conducted at 13 family planning clinics in Bangladesh, Haiti, Nepal and Nigeria. An effort was made to ensure that the questionnaires were as uniform as possible at all sites while at the same time meeting the needs of each participating clinic. All

nonsterilized women of reproductive age visiting the clinic for any contraceptive or health-related reason were eligible for interview.\* Respondents were asked about several background characteristics: their age, education, desired family size, current and past contraceptive experience, breastfeeding status, access to family planning services and previous knowledge of NORPLANT, as well as the source of any such information. Centers in Nigeria and Haiti also collected information on the respondents' religion, literacy and willingness to pay for the implants.

As part of the interview, respondents were read a fact sheet that included information on how NORPLANT works, its effectiveness, its possible side effects and how it is inserted and removed. No special fact sheet was provided for other contraceptive methods offered at these clinics (e.g., the pill, condom, IUD, injectables, and male and female sterilization), but normal informational materials and counseling were available. The same fact sheet was read to all women interviewed in each country. Afterwards, each woman was asked if she would be interested in using the contraceptive implant and what additional information she would like to have. She was then asked an open-ended question on her reasons for wanting or not wanting to use the method. The respondent was also asked to indicate which of a number of preselected reasons were important in her decision. (These responses had been identified during pretests of the survey instrument and were based on responses to an open-ended question on reasons for wanting or not wanting to try NORPLANT.)

Although the circumstances and services provided varied somewhat from clinic to clinic, the sites participating in the survey were primarily full-service family planning clinics; most provided oral contraceptives, condoms, IUDs and female sterilization procedures, and at least some offered injectables and male sterilization. (Some also provided maternal and child health services.)

Fieldwork began at the first two clinics in February 1985 and was completed at all sites by July 1986. For reasons of cost and logistics, the total number of interviews at each clinic was not to exceed five times the number of NORPLANT acceptors who were enrolled in the clinical trials being organized at each facility. Interviews were carried out only during the recruitment period for the clinical trials, and were conducted upon a woman's arrival at the clinic. The questionnaires were admini-

stered by trained social workers and interviewers at all sites except for one in Nepal, where the interviews were also conducted by motivators or health workers at satellite clinics in surrounding communities where participants in the NORPLANT trials were being recruited.

For this comparative analysis, data were pooled after we excluded three of the 13 participating centers because of data collection problems: one Nigerian center, because questionnaires were completed almost solely for NORPLANT acceptors; one in Bangladesh, because apparently only women eligible to receive the method (according to the clinical trial criteria) were interviewed; and one in Haiti, because the majority of acceptors were not interviewed. Thus, the sample consisted of women who had visited two clinics in Bangladesh, two clinics in Haiti, two clinics in Nepal and four clinics in Nigeria.

Our original intention was to interview a random sample of women coming to each of the clinics for family planning services. However, in practice, each center ended up interviewing a very different subgroup of women. Undoubtedly, crowded conditions caused the clinics to simplify their procedures for carrying out the interviews. To increase the comparability of the samples, we confined the analysis to the subgroup of women most likely to be interested in NORPLANT. These "potential acceptors" are women coming to the facility to start contraceptive use, to switch methods or to obtain information specifically about NORPLANT. Women who were seeking sterilization are included as potential acceptors. However, we excluded women coming for contraceptive resupply or for maternal health care, and those bringing a child for a health care visit. The subgroup of potential acceptors varied in relative size from clinic to clinic, but confining the analysis to this group increases the comparability of the women across study centers.

Although all NORPLANT acceptors should have been interviewed before they began using the method, a few were not included or recorded as such in the survey, either because the specified sample size of respondents was reached before the target number of clinical trial participants was achieved or because information on some women who began using the method after completion of the interview was not noted on the questionnaire.

Of the 5,039 survey respondents, 2,586 potential acceptors were identified and included in this analysis; 973 of these actually began using the implants. Overall,

\*To be part of the clinical trials, women had to be aged 18-40, sexually active, not currently pregnant and readily accessible for follow-up; they could not have liver disease, jaundice, sickle-cell anemia, herpes gestationis, pelvic inflammatory disease, cancer, thromboembolic disease or hypertension; they must have had at least one pregnancy and must not have used injectable contraceptives in the previous six months. Additionally, in Haiti and Nigeria, women could not be exclusively breastfeeding a child, while in Bangladesh and Nepal, they could not be breastfeeding at all.

more than 90 percent of the women who ended up participating in the clinical trials at these 10 centers had been identified through the surveys as potential acceptors. Thus, our definition of a potential acceptor identified the vast majority of women interested in using contraceptive implants.

## Results

Table 1 reveals some variations in the social and demographic characteristics of potential NORPLANT acceptors. On average, those in the Nigerian sample were about 3-5 years older, had almost two more living children, had had around twice as many years of schooling and were much more likely to want additional children than potential acceptors in Bangladesh, Haiti and Nepal. About one-fourth of women in Bangladesh and Nigeria and almost half of those in Haiti and Nepal reported that they were currently breastfeeding their youngest child.

Between 57 percent and 66 percent of the women in Bangladesh, Nepal and Nigeria had come to the clinic to start contraceptive use, compared with 85 percent of those in Haiti. The proportion whose main reason for coming to the clinic was to get information on NORPLANT ranged from less than one percent in Nigeria to 18 percent in Bangladesh. Some 32-37 percent of the women in Bangladesh, Nepal and Nigeria were practicing contraception, compared with only seven percent in Haiti.

The social and demographic composition of the four samples may be very different from that of the general population of women in union. For example, compared with women interviewed in the 1985 Bangladesh Demographic and Health Survey,<sup>5</sup> women in this study were younger, better educated, more likely to have no children or one child and less likely to have four or more children. Variations may also have been caused by differences in the type of women who visit family planning clinics compared with the general population. Moreover, women who go to such facilities may not represent all women seeking family planning services, because of such factors as the location of the clinic (e.g., in an affluent district or urban slum area) or the services it provides.

About half of potential acceptors in Bangladesh and Nepal (52-53 percent) had heard about NORPLANT before the interview, compared with almost 60 percent in Nigeria and only 40 percent in Haiti. In the last two countries, the women were also asked how long before their visit they had heard of the method. More than half of the

**Table 1. Means and percentage distributions of background characteristics of potential NORPLANT acceptors, by country**

Characteristic	Bangladesh (N=821)	Haiti (N=411)	Nepal (N=814)	Nigeria (N=540)
<b>MEANS</b>				
Age	26.3	27.9	27.4	30.9
No. of living children	3.0	3.2	2.7	4.6
Education (in yrs.)	3.6	2.6	2.6	6.9
Age of youngest child	2.4	1.3	2.0	1.4
<b>No. of additional children wanted</b>				
All women	0.5	0.6	0.4	1.4
Women wanting more children	1.2	1.3	1.2	2.2
<b>% DISTRIBUTION</b>				
<b>Age-group</b>				
<25	31.5	29.8	35.4	10.9
25-29	41.5	35.4	29.8	27.8
30-34	19.4	20.4	19.5	30.9
≥35	7.6	14.4	15.3	30.4
<b>No. of living children</b>				
0-1	15.8	14.1	16.5	7.4
2	29.2	26.5	37.3	7.9
3	24.5	22.1	24.6	13.6
4-5	23.8	26.8	17.4	35.3
≥6	6.7	10.2	4.2	36.1
<b>Education (yrs.)</b>				
0	46.8	43.1	70.0	23.8
1-7	31.2	49.9	10.7	38.1
≥8	22.0	7.0	19.3	38.1
<b>Age of youngest child</b>				
<1	18.9	35.3	28.6	35.2
1	24.8	30.9	24.1	30.0
≥2	56.3	33.8	47.3	34.8
<b>Breastfeeding status</b>				
Yes	23.0	45.6	44.4	27.6
No	77.0	53.4	55.6	72.4
<b>Desire for more children</b>				
Wants no more	61.2	51.2	63.0	35.6
Wants more				
After 5 yrs.	31.8	36.8	6.3	18.1
Within 5 yrs.	7.0	12.0	30.7	46.3
<b>Additional children wanted</b>				
0	61.2	51.2	63.0	35.6
1	29.5	34.6	30.8	19.6
≥2	9.3	14.2	6.2	44.8
<b>Main purpose of clinic visit</b>				
Start use	58.2	84.9	56.8	65.7
Switch methods	24.2	6.8	32.8	33.5
Find out about NORPLANT	17.6	8.3	10.4	0.8
<b>Contraceptive use-status</b>				
Using	32.2	6.8	37.0	34.8
IUD	8.3	0.7	4.9	10.4
Pill	17.7	1.5	18.8	7.4
Injectables	1.3	1.5	5.9	0.9
Condom	3.0	2.7	5.8	2.8
Withdrawal	0.8	0.0	0.5	4.8
Other	1.3	0.4	1.1	8.7
Not using	67.8	93.2	63.0	65.2
<b>Total</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>

Nigerian women who said they had heard about it previously reported having first heard about NORPLANT on the same day as the interview, while virtually none (one percent) of the Haitian women gave this response. In contrast, only 21 percent of potential acceptors in Nigeria said they had heard about it more than two weeks before the interview, compared with 29 percent of Haitian women.\*

Between half and two-thirds of potential acceptors said they would be interested in trying NORPLANT (Table 2—page 52). The proportion who were undecided varied considerably, from only two percent in Haiti and four percent in Nigeria to 11 percent in Nepal and 20 percent in Bangladesh (not shown). Many Bangladeshi women were concerned that their husbands might not approve of the method, and could not say whether they were interested until consulting them.

Because contraceptive use and method choice have been found to vary significantly with a woman's age, parity, fertility desires and education, we looked at the association of these variables with the level of interest in trying NORPLANT. Table 2 shows that in Nepal and Nigeria, potential acceptors 35 years of age or older were nearly twice as likely as those under 25 to be interested in NORPLANT (61 percent vs. 35-36 percent); likewise, those with six or more living children and those who wanted no more children were substantially more likely than those with few children and those who wanted more children to be interested in the method. According to chi-square tests, the associations between women's interest in trying NORPLANT and these characteristics were statistically significant ( $p < 0.05$ ).

In Bangladesh as well, interest in NORPLANT was significantly ( $p < 0.05$ ) associated with having many living children and with wanting fewer than two additional children. In Haiti, on the other hand, only age was significantly associated with interest in trying the method. In Bangladesh and Nepal, women with no education were more likely to be interested in trying the implants than were

\*It was surprising that such a substantial proportion of Haitian respondents (and smaller proportions of those in the other countries) had heard of the method well before their clinic visit. No NORPLANT media campaigns were under way in the areas where the acceptability surveys were conducted. In addition, the clinical trials were the very first such trials to be organized in these countries and were carried out on a small scale. Thus, most information on NORPLANT must have been passed by word of mouth or, occasionally, by health or social workers who were recruiting participants for the preintroductory clinical trials.

**Table 2. Percentage of potential acceptors who were interested in trying NORPLANT, by background characteristics and country**

Characteristic	Bangladesh	Haiti	Nepal	Nigeria
<b>Total</b>	<b>54</b>	<b>67</b>	<b>48</b>	<b>52</b>
<b>Age-group</b>				
<25	49	66	35	36
25-29	55	70	50	46
30-34	59	77	56	54
≥35	56	48	61	61
<b>No. of living children</b>				
0-1	32	60	29	35
2	51	70	43	34
3	61	72	49	37
4-5	62	66	68	50
≥6	66	57	68	66
<b>Desire for more children</b>				
Wants no more	60	65	53	72
Wants more				
After 5 yrs.	54	75	33	63
Within 5 yrs.	14	51	35	33
<b>No. of additional children wanted</b>				
0	60	65	53	72
1	53	69	37	52
≥2	26	69	26	37
<b>Education (yrs.)</b>				
0	60	64	51	52
1-7	50	67	42	54
≥8	48	79	40	50
<b>Youngest child's breastfeeding status and age (mos.)</b>				
<b>Breastfed</b>				
<12	30	52	20	46
<b>Not breastfed</b>				
<12	73	75	72	49
12-23	54	76	40	55
≥24	56	70	64	55
<b>Contraceptive-use status</b>				
<b>Using</b>	<b>62</b>	<b>64</b>	<b>55</b>	<b>49</b>
IUD	54	•	55	39
Pill	64	•	72	45
Injectables	•	•	29	•
Condom	60	•	30	53
Withdrawal	•	•	•	44
Other	•	•	•	64
<b>Not using</b>	<b>50</b>	<b>67</b>	<b>43</b>	<b>54</b>
<b>Prior knowledge of NORPLANT</b>				
Yes	81	71	63	55
No	25	64	30	47
<b>Timing of knowledge</b>				
Day of interview	u	•	u	45
1-14 days before	u	65	u	73
2-4 weeks before	u	69	u	68
>4 weeks before	u	79	u	60
<b>Source of knowledge</b>				
Friend/relative	80	87	58	75
Clinic	83	50	48	51
Health worker	•	•	82	•
Other	•	•	•	56

\*Percentages not calculated because there were fewer than 15 observations.

Note: u=unavailable.

women with some education, while in Haiti, women with the most education were most interested in NORPLANT. In Nigeria, there was very little variation in interest according to amount of schooling.

Except in Nepal, women who desired children in the next five years were much less likely than others to be interested in trying NORPLANT. Furthermore, except in Haiti, interest was higher among those who wanted no more children than among those who wanted to wait five years. Interest in trying NORPLANT was greater among women who had heard of the method prior to the interview than among those who had not. Among women who had already heard about NORPLANT, interest in trying the method was lower in Nigeria (55 percent) than in Bangladesh (81 percent), Haiti (71 percent) or Nepal (63 percent); however, a large proportion of Nigerian women had heard about the method only on the same day as the interview, leaving them less time to consider using it. (Only 45 percent of Nigerian women who had heard of NORPLANT on the day of the interview were interested in trying it, roughly the same proportion as among women who had never heard of NORPLANT.)

Interest in NORPLANT in Nepal was higher among women who had heard about the method from health workers and family planning motivators who visited them in the village (82 percent) than among those first informed by friends or relatives (58 percent) or by clinic personnel (48 percent). In Bangladesh, interest was highest among women who had first heard about NORPLANT at the family planning clinic, while in Haiti and Nigeria, interest was highest among those who had first heard about it from a friend or relative.

Women in Bangladesh and Nepal who were current method users but wanted to switch methods were more interested in trying NORPLANT than were nonusers, a relationship not seen in Nigeria or Haiti. In Bangladesh and Nepal, pill users were the most interested in trying NORPLANT, while in Nigeria women who used "other" methods (predominantly abstinence) showed the highest interest. In Haiti, there were too few observations to allow method-specific assessment of interest. Problems with pill compliance, observed in many countries,<sup>6</sup> may be the reason that pill users found NORPLANT an especially attractive alternative.

Table 3 shows that in Nepal, among women interested in trying NORPLANT, the method's reversibility and the woman's feeling that sterilization was not

yet appropriate for her were the reasons mentioned most frequently as being important in their desire to try NORPLANT (by 85 percent and 81 percent of respondents, respectively). In Bangladesh and Haiti, on the other hand, the method's effectiveness (mentioned by 76 percent and 99 percent) and convenience (mentioned by 73 percent and 97 percent) were the most important reasons. In Nigeria, the fact that NORPLANT is a new and promising method and is highly effective were the reasons most frequently cited by women who wanted to try it (by 96 percent and 95 percent, respectively).

Table 4 shows that in all countries, the largest proportions of women who elected not to use NORPLANT cited a preference for other methods as a reason (51-83 percent). Fear of side effects was the next most frequently mentioned reason in Bangladesh, Nepal and Nigeria, (given by 69, 48 and 45 percent, respectively). Approximately one-third of the women in each country said that their husband would not approve and that this was an important factor in their decision, making this reason the second most frequently cited in Haiti and the third most often cited in Nepal. Fear of insertion and removal procedures was also frequently mentioned; concern about insertion was exceptionally high in Bangladesh. On the other hand, concerns that the capsules would be too visible and that people would know the woman was practicing contraception were not important reasons for lack of interest in trying NORPLANT.

Responses to an open-ended question revealed other important reasons behind some women's decisions not to try NORPLANT, such as concern about possible menstrual irregularities or about the newness of the method, a desire for more children in the next five years (and thus for a method of shorter duration), a perceived need for more information on the method, concern that they were too young or too old to use hormonal implants and not being currently married.

The overall proportion of women interested in trying NORPLANT who actually received it varied considerably across the four countries, from 52 percent in Haiti to 83 percent in Bangladesh (not shown). These differences were probably influenced by the number of women allowed to enter the clinical trials at each center, the volume of clients visiting the clinic and the proportion of respondents who were interested in trying NORPLANT.

There were also variations within countries in the proportion who accepted the

method: Among interested women, for example, the proportion who received NORPLANT was positively associated with education. Better educated women may be more likely to see the need for and the benefits of follow-up visits and therefore be more inclined to make them. Consequently, clinic staff may be more likely to favor educated women in providing NORPLANT: In all four countries, interested women with no education were somewhat less likely to have received NORPLANT than were women with eight or more years of schooling.

Besides the inclusion and exclusion criteria for the clinical trials, other factors probably affected the likelihood that interested women would actually receive NORPLANT, such as selectivity on the part of the clinic staff responsible for recruiting acceptors (for example, the staff's tendency to pick women they considered likely to keep the implants in the longest). The social and demographic variations could also be due to differences in the availability of other temporary methods and of sterilization, factors that might limit or expand a woman's contraceptive options depending on her age or parity, for example.

#### Discussion

Contraceptive acceptability studies can contribute to increased method acceptance and continuation by identifying issues and concerns that can direct the development of informational and motivational material useful for dispelling rumors and misinformation about the method and for improving service delivery. Such studies may also help to identify the obstacles that prevent some women who find a method acceptable from actually using it.

Studies such as those described in this article should help programs identify social or cultural factors and concerns about the method that might impede or enhance both the acceptance of NORPLANT and that of other long-acting steroidal contraceptives. For example, a clinic client may be interested in using the method but afraid to undergo the necessary physical examination, especially if the doctor is male. Other women may first have to ask their husbands for permission to use NORPLANT (or may fear to do so). Financial obstacles or problems of accessibility to the clinic may also reduce acceptance of the method by some interested women. Other women may be interested in the method but at too early a stage in their reproductive life to consider such a long period for spacing births.

The acceptability surveys conducted in these four countries revealed a relatively high level of interest in using NORPLANT among potential acceptors. Many women mentioned that they liked various aspects of the method, such as its reversibility, effectiveness and convenience. Although the survey identified some potential obstacles to NORPLANT acceptance (such as concerns about menstrual irregularities and about husband's disapproval), interest in trying the method appears high. We have also identified a target group of potential acceptors most likely to want to try the method: women in their late 20s or older who have had a few children and who are interested either in spacing births for at least several years or in limiting births but who are not ready to use a permanent method.

The results of the surveys also point to the need for thorough counseling to reduce the apprehensions that both women and their husbands may have about this new method. Service providers must pay close attention to women's concerns regarding such issues as menstrual irregularities, insertion and removal procedures, side effects and return to fertility. In particular, the bleeding and other menstrual irregularities that some women experience while using NORPLANT could reduce the overall acceptability of the method in societies with strict customs and practices relating to menstruation. Additionally, in countries where the status of women is low and their rights limited, the husband's knowledge and approval of a method are likely to be important determinants of acceptability. Thus, because husbands can be an obstacle to women's acceptance of NORPLANT, service providers should increase their efforts to involve husbands in counseling services and information dissemination.

In the analysis reported here, we did not attempt to differentiate interest in NORPLANT from interest in other long-acting reversible methods. Thus, we do not know whether the responses would have been the same if the method described had been a new six-month injectable or a new IUD. Preference for other methods was a major reason potential acceptors gave for not wanting to try NORPLANT. Perhaps the next step is to investigate preferences for NORPLANT versus preferences for other new long-acting methods, in terms of both initial acceptance and continuation. Another approach could be to look at the acceptability of NORPLANT relative to that of IUDs for women who wish to space births for a year

Table 3. Percentage of respondents interested in trying NORPLANT who reported that various preselected reasons were important in their decision, by country

Reason	Bangladesh (N=444)	Haiti (N=275)	Nepal (N=383)	Nigeria (N=281)
Effectiveness	76	99	75	95
Newness and promise	61	97	67	95
Safety	61	87	60	92
Convenience	73	97	72	94
Reversibility	68	70	85	84
Unreadiness for sterilization	41	69	81	50

or more. Since both implants and IUDs must be inserted and removed by a trained medical person, an evaluation of the relative popularity and acceptability of each might be worthwhile. Furthermore, in countries where NORPLANT has been available for some time, it might be useful to conduct population-based acceptability surveys to assess general attitudes toward, perceptions of and interest in the method. One such study has been conducted, in Sri Lanka.<sup>7</sup> Continuing efforts should be made to monitor the interest in, acceptance of, satisfaction with and continuation of NORPLANT use as this method becomes an increasingly important contraceptive option.

Table 4. Percentage of respondents not interested in trying NORPLANT\* who reported that various preselected reasons were important in their decision, by country

Reason	Bangladesh (N=377)	Haiti (N=138)	Nepal (N=426)	Nigeria (N=259)
Prefers other method	73	83	51	71
Fears side effects	69	36	48	45
Fears insertion	50	38	33	31
Fears removal	20	38	32	31
Believes method is not good for her	43	24	34	38
Fears husband's disapproval	34	41	37	29
Does not want capsules in body	19	26	36	30
Believes method may show in arm	4	8	22	17
Fears people may know she is using a method	1	7	15	12

\*Includes those who were undecided.

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Resumen

Un estudio de 2.586 posibles aceptantes de implantes contraceptivos hormonales NORPLANT® que fueron entrevistadas en 10 clínicas de planificación familiar en Bangladesh, Haití, Nepal y Nigeria revela un alto nivel de interés: De 48 a 67 por ciento de las entrevistadas que habían acudido a las clínicas para empezar el uso anticonceptivo o para ob-

tener información acerca de NORPLANT, y que se consideraban como posibles aceptantes de implantes, expresaron interés en el método. Una gran proporción de las mujeres identificó la eficacia, la reversibilidad y la conveniencia de los implantes como sus aspectos más atractivos. Las mujeres mayores de 25 años que ya tuvieron varios hijos y que querían limitar o espaciar los partos por lo menos unos años, pero que no estaban dispuestas todavía a esterilizarse, eran las más interesadas en NORPLANT. Los resultados también demuestran la necesidad de tener un programa de asesoramiento cabal a fin de reducir las aprensiones que las mujeres y sus maridos puedan sentir con respecto al método, como por ejemplo, miedo de los efectos secundarios o del procedimiento de inserción y extracción.

Résumé

L'analyse de 2.586 femmes potentiellement prêtes à accepter l'implant contraceptif hormonal NORPLANT®, selon les résultats d'entrevues organisées dans 10 cliniques de planification familiale au Bangladesh, à Haïti, au Népal et au Nigéria, révèle un degré d'intérêt élevé pour la méthode NORPLANT: entre 48 et 67 pour cent des femmes interrogées qui s'étaient adressées aux cliniques pour entamer une méthode contraceptive ou s'informer sur la méthode NORPLANT et qui étaient considérées comme potentiellement prêtes à accepter l'implant ont exprimé leur intérêt pour la méthode. Une grande partie d'entre elles ont souligné parmi les caractéristiques les plus attractives de l'implant son efficacité, son caractère réversible et sa commodité. Les femmes aux alentours de la trentaine ou plus, déjà mères de plusieurs enfants et souhaitant soit espacer les naissances de quelques années au moins soit tout simplement les limiter, mais n'étant pas encore prêtes à se faire stériliser, se sont avérées les plus susceptibles d'intérêt pour la méthode NORPLANT. Les résultats de l'analyse soulignent également le besoin d'une consultation approfondie afin de dissiper les appréhensions ressenties par la femme et son conjoint au sujet de la méthode, notamment la

crainte d'effets secondaires ou de la procédure d'insertion ou de retrait de l'implant.

Characteristics of Chinese Children

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hijos únicos residentes en zonas urbanas demostraron un desempeño escolar marcadamente superior; a la de sus pares no hijos únicos; no se verificó ninguna diferencia en esta medida entre los niños residentes en zonas rurales. A pesar de que los maestros de los niños tendían a evaluar a los hijos únicos como más virtuosos y competentes que los niños con hermanos, la evaluación de los niños por sus propios padres, usando las mismas medidas, no revelaron mayores diferencias entre los dos grupos.

Résumé

Une étude des effets de la politique démographique chinoise sur les résultats scolaires et la personnalité de l'enfant unique a été entreprise en 1987 parmi les écoliers de Changchun, dans la province de Jilin. Les résultats ne sont pas venus confirmer les rapports publiés dans la presse chinoise et occidentale selon lesquels la politique chinoise de l'enfant unique était en train de créer une génération d'enfants gâtés. Dans l'ensemble, les résultats scolaires de l'enfant unique se sont révélés sensiblement supérieurs à ceux de ses camarades non uniques, mais l'on n'a relevé aucune différence majeure au niveau de la personnalité. Dans les sous-catégories de résidence en milieu urbain ou rural et par année d'études, on a observé des résultats scolaires sensiblement supérieurs chez les enfants uniques vivant en milieu urbain par rapport à leurs camarades non uniques; aucune différence de la sorte n'est apparue parmi les enfants originaires de milieux ruraux. Malgré une tendance chez les enseignants à qualifier l'enfant unique de plus apte et compétent que l'enfant non unique, l'évaluation par les parents de leurs propres enfants, sur la base des mêmes échelles, n'indique aucune différence majeure entre les deux groupes.

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