

**WOMEN'S VOICES, WOMEN'S LIVES:  
THE IMPACT OF FAMILY PLANNING**



**A Synthesis of Findings  
from the  
Women's Studies Project,  
Family Health International**

**Barbara Barnett  
with Jane Stein**

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June 1998

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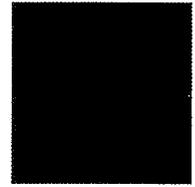
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# EXECUTIVE SUMMARY



**T**he Women's Studies Project (WSP) at Family Health International (FHI) is a five year effort to study the impact of family planning on women's lives. To determine women's perspectives on this issue, researchers went directly to the women themselves, asking them which research issues were important to study, whether they felt they had or had not benefited from family planning methods and services, and, if so, how. Twenty six studies were conducted in 10 countries, and both qualitative and quantitative data were collected and analyzed. Women expressed their views on family planning in surveys, in focus group discussions (FGDs) and in depth interviews. Additional information was gleaned early in the WSP from secondary analyses of data collected in previous projects in four countries and through three case studies on women centered health programs. The Project was supported by a Cooperative Agreement to FHI from the U.S. Agency for International Development, with the exception of a study in China, supported by the Rockefeller and Ford Foundations, and a pilot project in the Republic of Korea (South Korea), supported by FHI.

The Women's Studies Project sought to move beyond studying the impact of family planning on women's physical health. The studies examined how women's family planning experiences — their contraceptive use and non use, their pregnancies and childbearing, and their experiences with family planning and reproductive health programs — affected other aspects of their lives, including their roles as individuals, as family members and as participants in the larger community. Some studies interviewed women's relatives, including husbands or partners, parents and in-laws, to determine how

family interactions and power dynamics influence contraceptive experience and use.

The diversity of WSP research topics reflects the diversity of women's concerns:

- strategies developed by new users to cope with family and community opposition to contraceptive use (Mali),
- generational differences in family planning experiences (China),
- the impact of men's views on women's contraceptive behavior (Bolivia),
- the impact of family planning on women's domestic lives (Indonesia),
- the impact of tubal ligation on quality of life (Brazil),
- the social and behavioral consequences of unintended pregnancy (Egypt),
- the effects of gender on adolescent views of sexuality (Jamaica),
- the impact of family planning on women's self esteem and self image (the Republic of Korea)
- the impact of family planning use on women's participation in the work force (the Philippines), and,
- family planning and women's participation in the development process (Zimbabwe)

These and other topics were selected by colleagues in countries participating in the WSP, including researchers, policy makers and providers, and women's health advocates. This "triangle" became a critical component of the research

process. Members of the triangle were represented on In-country Advisory Committees (IACs), which worked in each WSP emphasis country (countries that were the site of more than one WSP study) to establish the research agenda, monitor the research process and plan dissemination of research results.

To guide research and data analysis, the WSP developed a conceptual framework, based on previous models and research. This framework incorporated the complex and multidimensional aspects of women's lives, considered the possibility that strong external factors, such as gender norms and sociopolitical climates, influence women's use of and experience with family planning, and placed family planning in the larger context of women's reproductive health needs.

The WSP sought to understand the multiple factors that affect the impact of family planning. Studies illustrate the differences in perceptions that exist between women and men, and among women, due to age, culture, place of residence, socioeconomic class, religion, and gender norms. However, commonalities emerged, which the WSP has formulated into 16 research themes.

### **GENERAL THEMES**

- Family planning affects numerous domains of women's lives — domestic, economic and community spheres
- Gender norms strongly influence women's family planning experiences

### **BENEFITS TO WOMEN**

- Most women and men are convinced that practicing family planning and having smaller families provide economic and health benefits
- Family planning offers freedom from fear of unplanned pregnancy and can improve sexual life, partner relations and family well being
- Where jobs are available, family planning users are more likely than non users to take advantage of work opportunities
- Family planning helps women meet their practical needs and is necessary, but not sufficient, to help them meet their strategic needs

### **COSTS TO WOMEN**

- Contraceptive side effects — real or perceived — are a serious concern for many women, more than providers realize
- When partners or others are opposed, practicing family planning can increase women's vulnerability
- When women have smaller families, they may lose the security of traditional roles and face new and sometimes difficult challenges, including the burden of multiple responsibilities at home and work

## **BARRIERS TO CONTRACEPTIVE BENEFITS**

- Social, political and economic barriers limit benefits of family planning for many women
- The benefits of family planning are reduced when contraceptive methods are ineffective, used incorrectly or inconsistently, or discontinued early (before pregnancy is desired)
- For some adolescents, pregnancy is wanted
- Family members — particularly husbands — play a critical role in the quality of women's experiences with family planning
- Women reap fewer benefits if family planning is initiated late in reproductive life

## **SERVICE DELIVERY ISSUES**

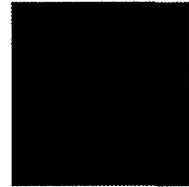
- Men often have a dominant role in family decisions but tend to be marginalized by family planning programs
- Women are generally satisfied with family planning services but want more female providers, more emotional support, help with side effects and more information on contraceptive methods

One of the main purposes of the WSP is to encourage the use of research findings to improve the quality of women's reproductive health services, and indeed, the results have clear implications for health policies and programs. For example

- Contraceptive counseling must take into account gender norms and the barriers they may pose to family planning
- Peer networks should be established, in which experienced contraceptive users counsel new users about the everyday realities of method side effects
- Men and other key family members need to be educated about family planning to help them make informed decisions about family planning use and to support women's contraceptive choices
- Counseling should emphasize the benefits of contraceptive use beyond health and economics, including emphasis on improvement in family relationships
- Family life education should begin early, and women should be encouraged to view family planning use as a component of life long reproductive health

The WSP found that while women perceive numerous benefits of family planning use, they also see negative consequences, such as family disapproval and method side effects, which can discourage them from taking control of their fertility. Women's dual perspectives should be taken into account as researchers, women's advocates, policy makers and providers work collaboratively to improve family planning services. By understanding the intricate realities of women's lives and the factors that affect their reproductive health behaviors, family planning programs can offer services that match women's needs and ultimately can help improve the quality of women's lives.

# I. INTRODUCTION



**A** primary purpose of the Women's Studies Project (WSP) at Family Health International (FHI) is to put women's voices at the center of family planning research

By supporting 26 social and behavioral science field studies, plus five secondary analyses, in 14 countries, the WSP has sought to increase the body of knowledge on women's family planning experiences and to increase understanding of how women perceive the immediate and long term consequences of family planning programs and methods. The ultimate goal of the Project is to provide new information to policy makers and providers that can improve reproductive health services and policies.

Begun in October 1993 under a Cooperative Agreement with the U.S. Agency for International Development (USAID), the WSP was designed to explore the impact of family planning programs on women's lives by asking women directly how they felt they had benefited — or not benefited — from contraceptive use.

The WSP began at a crucial juncture in the evolution of global population policy. In the early 1990s, donors, women's advocates and public health organizations increasingly called for changes in the population research agenda. The success of family planning programs, they observed, typically had been measured by numbers — declines in fertility rates, increases in the number of contraceptive users, couple years of

protection, or achievement of country wide targets. Little consideration had been given to whether family planning programs, in meeting these demographic goals, actually enhanced or

improved individuals' lives. Author Ruth Dixon Mueller noted that "little is known about how family planning clients interpret their sexual lives or what providers can do to help women gain more effective control over their sexuality and reproduction."<sup>1</sup>

During the five years in which WSP research was conducted, two landmark events occurred. In 1994, the International Conference on Population and Development (ICPD) was held in Cairo, Egypt, and in 1995, the Fourth World Conference on Women was held in Beijing, China. Both conferences reaffirmed the need for a change in perspective — the need to view family planning not as an end unto itself, but as means to help women and men improve their reproductive health.

Reproductive health, in turn, was seen as essential to women's empowerment as defined by the ICPD Programme of Action:

'Reproductive health is a state of complete physical, mental and social well being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes. Reproductive health, therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide



*" Yes, people are  
happy with  
family planning.  
They see that  
their family is in  
harmony, their  
children are big  
enough to take  
care of themselves,  
while the  
mother can take  
care of herself "*

**Woman in rural  
North Sumatra  
Indonesia**

if, when and how often to do so. Implicit in this last condition are the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice. In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well being by preventing and solving reproductive health problems.”<sup>2</sup>

At the Fourth World Conference on Women, participants reaffirmed the ICPD’s recommendation that family planning be placed in the context of reproductive health. The Beijing Programme of Action noted that “women are subject to particular health risks due to inadequate responsiveness and lack of services to meet health needs related to sexuality and reproduction,” and the document called for the “mainstreaming of a gender perspective into all policies and programs.”<sup>3</sup> Other reports called for increased access to family planning, noting that choices about contraceptives and other aspects of life are essential to human dignity.<sup>4</sup>

The Women’s Studies Project anticipated some of the recommendations of the two conferences in developing and implementing research projects. For example, the WSP included women, not only as research respondents, but as principal actors in all phases of the research process — from study design through information dissemination. Women were included in the triangle of WSP collaborators — women’s advocates, policy makers and providers, and researchers.

During the course of the five year project, the WSP sought to promote local ownership of research and to build the capacity of developing country colleagues to conduct research and disseminate information. Consequently, the research process was as important as the research agenda. During initial needs assessment visits to countries that expressed interest in the Project, FHI staff met with members of the triangle. Later, representatives of these groups formed In-country Advisory Committees (IACs), which helped to develop the research agenda in their specific countries, monitor the progress of the studies, and plan efforts to disseminate research results to a wide audience,

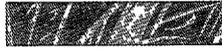
including study participants. To ensure that women’s voices were indeed heard, researchers used both qualitative and quantitative methods. Focus group discussions were used as a guide to help develop research questions and indicators and, along with in depth interviews, were used to add depth and context to quantitative data. Case studies were written to profile local women centered health programs, in an attempt to learn how family planning had been integrated with other types of reproductive health services.

The objective of the WSP appeared simple to assess the impact of family planning on women’s lives. However, actually determining that impact is complex and difficult. Family planning use affects numerous aspects of women’s lives, including their roles in the family and work place, but aspects of women’s lives also affect their family planning use. In implementing studies and analyzing study results, the impact of family planning could not always be easily measured or isolated. For this reason, many of the WSP studies explored family planning in the context of women’s lives — their psychosocial well being, domestic lives, work lives, and position within the community.

To guide the research process, the WSP staff reviewed various conceptual frameworks and developed a framework of its own to explore the relationships between family planning and women’s lives. Originally, the Project was envisioned as comparative research based on similar studies in different countries, and the WSP staff developed a core questionnaire reflecting the conceptual framework. However, as the Project evolved, staff recognized the importance of supporting the needs, interests, and skills of the local colleagues. Consequently, the core questionnaire, when used, was adapted by local researchers to complement their in-country research agenda. A Technical Advisory Group (TAG), comprised of international experts in diverse disciplines, was established to provide WSP staff with feedback on the research process and results. Again, the triangle of providers and policy makers, women’s advocates, and researchers was reflected in the TAG membership (see Appendix 1).

Selection of countries to participate in the WSP was based on both country interests and USAID's priorities. After initial visits by FHI staff, conversations with in-country colleagues, and consultation with USAID, six "emphasis" countries were selected. These countries, each of which was the site of multiple WSP studies, were Bolivia, Brazil, Egypt, Indonesia, the Philippines and Zimbabwe. The WSP also supported a single study in the two "associate" countries—Jamaica and Mali. A grant from the Rockefeller Foundation supported research in China.<sup>†</sup> Funds from FHI were used for a small pilot project in the Republic of Korea (South Korea). In addition, the WSP supported secondary analyses of existing data in the Philippines, Bangladesh, Nigeria and Malaysia.

In this paper, we discuss the research methodologies used in the WSP in Section II. In Section III, we present crosscutting themes that emerged from the research and some implications for reproductive health policies and programs. In Section IV, we provide an overview of the conceptual framework that guided the research process and data collection. We offer some lessons learned in Section V and suggestions for future directions in Section VI. We conclude with summaries of individual research projects, grouped by region and country, in Section VII.



*"If I had [had] access to the method of preventing pregnancy, I wouldn't have been pregnant and I would have finished my O-levels and, you never know, I might have passed. And I would be working somewhere in town, and maybe I would be having a better life than this one."*

**Zimbabwean woman**

Each study, including sample information and scope, is briefly described and key results are listed in Appendices 4 and 5.

This report is a summary of results from 26 field studies available as of March 1998. The report is intended as a synthesis of findings for a general audience, and therefore, does not include detailed data from the hundreds of analyses carried out by research teams. Instead, illustrative findings, tables and quotes from study participants are presented to support the crosscutting themes that emerged from the WSP. The final reports on which this synthesis is based are listed in the Appendices, and additional reports will be made available through FHI's web site (<http://www.fhi.org>). Further primary and secondary analyses, as well as several longitudinal studies (for example, in Brazil and Mali), are ongoing and will be completed within the next few months. The WSP also will submit its findings in scientific papers to peer-reviewed journals.

The knowledge and insights gained from the WSP can be used in the ongoing discussion among women's advocates, policy makers and researchers, who share the common goal of improving reproductive health services and women's lives. By taking into account women's perspectives and experiences, family planning programs can help make access to quality reproductive health services not just a goal, but a reality.

<sup>†</sup> The study in China, which took place in two provinces—South Jiangsu and North Anhui—will be replicated in a third province—Yunnan. Research in Yunnan is supported by the Ford Foundation.

## II. RESEARCH METHODOLOGY



No single research method can adequately address the complex interrelationships between family planning and women's lives. Therefore, the WSP used multiple methods. Through a participatory process and in collaboration with FHI staff and consultants, investigators in each country identified critical questions about women's experiences with family planning and designed their studies to answer these questions. The nature of the research questions determined methodologies used and often required combinations of techniques to explore issues from different perspectives. (See Appendix 4 for a detailed list of subprojects and research methods.)

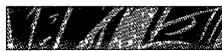
Of the 26 WSP field studies, 20 used both qualitative and quantitative methods. Two used quantitative methods only, while four were entirely qualitative. (The remaining subproject focused on guideline development.) WSP investigators typically collected both qualitative and quantitative data, using the two approaches to complement each other and bring different strengths and challenges to the research process. Quantitative data describe, while qualitative data interpret. Quantitative studies measure occurrences, trends, and relationships, generalize findings to larger populations, administer structured questionnaires, and essentially ask, "How many? How often? and How is one thing related to another?" Qualitative approaches seek depth, insight, and understanding. They explore the perceptions of individuals and groups, stress intuitive judgment, invite study

participants into a dialogue, and ask "Why? How? under what circumstances?"

Quantitative methods used in the WSP included longitudinal and cross-sectional surveys, follow-up surveys of participants in prior studies, situation analyses, inventories, and secondary analyses of existing data. For example, in Cebu, the Philippines, investigators used a discrete time life event history analysis to link women's contraceptive and birth histories with retrospective accounts of economic events in their lives. A modified version of this technique was used in Zimbabwe to study women's participation in development activities.

Qualitative methods included focus group discussions, in-depth interviews, case studies, and secondary analysis of ethnographic data. In Mali, for example, a longitudinal qualitative study explored the experiences of new contraceptive users through a series of in-depth interviews.

In some studies, the WSP combined qualitative and quantitative methods to provide greater understanding of women's experiences, women and men's decision-making behaviors, and women's multiple roles. In other studies, qualitative methods helped to develop and refine quantitative techniques — for example, to identify cultural norms and vocabulary, to determine key variables including psychosocial measures, and to clarify research questions. And in other studies, qualitative methods contributed to a better understanding of findings produced by quantitative methods. (See Section VII for detailed



*"Working in family planning gives me the confidence to share in these [household] decisions"*

**Female employee in Kafr El Seikh, Egypt**

country specific descriptions of methods, findings and policy implications )

An illustration of the integration of qualitative and quantitative methods as parallel tools is found in Egypt, where researchers collected quantitative data to describe female participation in the family planning labor force, and qualitative data (through focus group discussions) to explore employees' perceptions of their jobs. In Jamaica, adolescents participating in the Grade 7 Project, designed to delay first pregnancy, completed a questionnaire, administered by an interviewer once before students began the program and twice after they entered the program. Between surveys, students also participated in focus group discussions, where moderators encouraged them to express their views on family planning, parent hood and norms for sexual behavior. In China, selected study participants who took part in both a sample survey and focus group discussions provided rich insights into how lower fertility affects women in different domains of their lives. In Bolivia, a study of women's access to and use of reproductive health services used situation analysis, with the addition of focus group discussions and interviews, to understand clients' perceptions of reproductive health needs and barriers to services.

In several countries, data from qualitative studies informed or shaped quantitative research instruments. Researchers in the Philippines drew on focus group transcripts to develop survey questions. Filipino researchers also enriched the analysis of a household survey from a longitudinal study in Cebu with data from in depth interviews. WSP investigators in Bolivia developed psychosocial indicators from focus group discussions and included the items in a structured interview on male attitudes toward family planning. Similarly in Brazil, a comparative study on the impact of female sterilization on women's lives benefited from focus groups discus-

sions, which led to development of psychosocial measures for a survey. Focus group discussions with youth in Alexandria and Assiut, Egypt, helped researchers develop questionnaires on adolescent reproductive health.

In other subprojects, qualitative methods complemented quantitative findings. A study in Indonesia included secondary analyses of data from the 1993 Indonesia Family Life Survey (IFLS) to examine the impact of family planning on women's labor force participation. Researchers also conducted in depth interviews to answer questions not covered in the IFLS, such as the effect of women's family planning use and labor force participation on their household autonomy. In another Indonesian study on family planning and women's empowerment, in depth interviews with a sub sample of 800 survey respondents provided insight into why method switching and discontinuation rates are high. In South Korea, a secondary analysis of national statistical data on women's fertility and work, combined with focus group discussions among women in different age groups, enabled researchers to explore generational perspectives. Cross generational comparisons were also used in China to examine the impact of rapid fertility decline following a sweeping change in national family planning policy.

In many cases, quantitative findings validated qualitative findings, and vice versa. In Cebu, the Philippines, comparison of a sub sample of women responding to a survey on family decision making found that the women gave similar responses during in depth interviews. In Zimbabwe, both quantitative and qualitative research findings showed that

women typically use contraceptives only after they have proven their fertility.

In other studies, qualitative and quantitative findings were, at times, contradictory. In the study, *Family Planning, Family Welfare and Women's Activities in Indonesia*, quantitative findings (based



*" If family planning  
had been  
available earlier,  
my future would  
have been different  
That is my  
life-long regret  
Because I had  
too many children,  
I had to quit  
[teaching] "*

**Woman in South  
Jiangsu China**

on bivariate and multivariate analyses) showed that family planning and fertility had only a modest effect on women's social and economic activities and on family welfare. However, in in-depth interviews, most women cited family planning as an important factor that improved the overall quality of their lives. In China, the majority of women who responded to a survey said they were satisfied with their current contraceptive method. Yet in focus group discussions with a sub-sample of survey respondents, women said they worried about contraceptive failure.

In some studies, a qualitative component shed new light on research findings. In Bolivia, for example, female survey respondents spoke of husbands' "jealousy." When researchers probed the meaning of this term in focus group discussions, they learned that jealousy is a euphemism for domestic violence. In Korea, annual surveys found that younger women, who had more experience with family planning and smaller families than older women, also had more work opportunities. However, focus group discussions revealed that younger women felt stress and tension as they sought to balance their work inside and outside the home — something older women, who typically quit their jobs when they married, had never encountered. In Jamaica, adolescents responding

to a questionnaire said that contraceptives were used primarily by teens with multiple sexual partners. However, in focus group discussions, they expressed positive attitudes toward contraception and agreed that the use of family planning indicates responsible behavior.

One characteristic of qualitative data is that it leads to new questions for analysis. Qualitative analysis is an inductive process; themes emerge as the analysis unfolds. Thus, researchers return to their data with new questions and revised perspectives as analysis progresses. Quantitative studies also may have implications for further research, but investigators are more restricted by the original questions.

Most WSP-supported investigators initially had stronger skills in quantitative methods, which increased the need for technical assistance by FHI staff in qualitative techniques, including the integration of qualitative results in final reports. The interest of in-country colleagues in qualitative methodology suggests an important area for future technical assistance. Although the use of multiple methods can be costly in terms of efficiency and time, the advantages far outweigh the disadvantages for capturing the complexity of women's lives while simultaneously describing more general patterns of behavior and experience.

### III. CROSSCUTTING THEMES AND THEIR IMPLICATIONS



The Women's Studies Project is like a mosaic. Each small, individual component comprises a larger whole, creating a unique image. Although the WSP subprojects varied in their scope of work and research goals, when viewed collectively, they create a new picture of women's perspectives. In spite of tremendous differences — in ages, religious beliefs, economic and work status, wealth, educational backgrounds and family size — study participants shared common experiences and perceptions.

The WSP experience indicates that women's view of family planning is panoramic. Women see contraceptive use as one of many elements of reproductive health, see reproductive health as one element of overall health, and see health as one element of quality of life. Women say health is linked to other aspects of their lives: to their families, their economic conditions, and their goals and values. Family planning's effects are multifaceted and multidimensional. Women may have long held this broad perspective, however, policy makers and researchers have only recently begun to adopt similar views as they question women in depth about their perceptions and experiences.

Qualitative and quantitative data from different countries in the WSP show that women generally believe family planning is beneficial. For example, in Zimbabwe, women and men said family planning was an important element of quality of life. In Indonesia, couples said family planning offered them a means to achieve financial stability and harmony within the home. However, for many women, contraceptive use carries a price. Side effects can limit women's physical activities, and the disapproval of family members may exact an emotional toll. Women who use family planning

say it gives them freedom to pursue education and jobs, but this freedom exists within the context of gender norms, family dynamics and economic realities that limit women's opportunities.

Investigators found differences among and within countries participating in the WSP — differences between users and non users, men and women, providers and clients, rural and urban residents, socioeconomic classes, and women of different ages. These will be described in Section VII, entitled Research Findings. What follows are the broader themes that emerged in the analysis of the multiple subprojects related to family planning and women's lives. In keeping with the Project's objective of using research to suggest changes in health policies and programs that reflect the needs and concerns voiced by women, implications and recommendations follow the discussion of each theme.

#### GENERAL THEMES

*Family planning affects numerous domains of women's lives, including domestic, economic and community spheres.*

Family planning is often discussed in terms of its impact on women's physical health. However, WSP research indicates that women often view family planning in broader terms, as a long term activity that affects the quality of their psychological health, their domestic lives, their ability to participate in the work force, and their ability to join in community activities.

For some women, family planning experiences increase their self esteem and autonomy. A study in Cochabamba, Bolivia, found that

modern contraceptive users had higher levels of self determination than non users and also were more satisfied with their sexual relationships

Several WSP studies suggest that family planning use leads to improvements in couple relationships and stability at home In Zimbabwe, a woman explained that “without family planning and the consequent child spacing and limitation, there is not quality of life As a woman, you can not get enough time to give love to your children and your husband if you have many children ”<sup>5</sup> In Mali, women said that with smaller families, they had more time to devote to their husbands and children And in Indonesia, where the government family planning program has been in place for more than two decades, couples saw contraceptive use as a source of domestic tranquillity A woman from North Sumatra said, “Yes, people are happy with family planning They see that their family is in harmony, their children are big enough to take care of themselves, while the mother can take care of herself ”<sup>6</sup>

In the WSP, study participants said contraceptive use definitely affects their ability to work and go to school In Brazil, adolescents who sought treatment for complications from induced abortions were nine times more likely to be in school than adolescents who carried their pregnancies to term In Zimbabwe, female students were frequently asked to leave school if they became pregnant and often did not return after the birth of a child because they were no longer interested, had no time, or had no money<sup>7</sup> Mothers in law often volunteered to be caretakers for grandchildren if daughters in law returned to school, they saw younger women’s loss of education as potential loss of income for the family “Life is becoming tough,” said one older woman “It is different now from long ago when a working man would manage his family In today’s life, you need to help each other ”<sup>8</sup>

Women had mixed views about whether family planning helped or hindered their participation in the work force In Mali, women said family planning was a way to gain more time for work inside and outside the home However, for women in Bangladesh who experienced side effects, contraceptive use was often seen as a barrier to work One



CYNTHIA WASZAK/PHI

*Couples in Zimbabwe said family planning is an important element of quality of life*

woman, who used oral contraceptives, said, “The man of the house never likes it if the woman can’t work He says, ‘Did I marry you to keep you as a pet? I married you to work in my house! If you sit around, who will look after the children, and who will do all of the chores?’ This is why I stopped taking the pills ”<sup>9</sup>

In some studies such as those in China and Zimbabwe, women and men said that family planning enhanced their ability to earn income, and this was viewed as beneficial In the Philippines, women said family planning allowed them to work outside the home However, with little or no relief from domestic chores, women did not necessarily see this opportunity as positive Women spent an average of 46 hours per week working outside the home — yet they also spent an average of 23 hours doing housework

In Egypt, where female family planning workers were interviewed, women were proud of their jobs However, they said their work, coupled with their domestic responsibilities, created stress They felt they did not have enough time to take care of



*“ Without family planning and the consequent child spacing and limitation, there is not quality of life ”*

**Zimbabwean woman**

their children and too little time to devote to their own needs. In Indonesia, women approved of family planning but were not enthusiastic about working outside the home, since they felt it would detract from their duties as mothers and wives.

The dual burden of domestic and work roles was evident in South Korea. Since the 1960s, when the government implemented a nationwide family planning program that encouraged couples to have only two children, the country's fertility rate has declined. The "fertility revolution" has given women additional opportunities in the work place, and men have become more involved in domestic chores. However, this change has sometimes led to family conflict and lower self-esteem for women. Many drop out of the work force around the time they marry or have their first child because their domestic and work responsibilities are too heavy. "I came out of the house at dawn, went to school and taught many students all day long," said one woman. "Teaching was a hard working job. But even after I returned home, my labor did not finish because the housework, which is always a wife's job, was left undone. It was so hard, I couldn't help quitting the job."

Some women felt contraceptive use allowed them to participate in formal community activities, including political campaigns. However, many women, such as those in the Western Visayas in the Philippines, said their involvement was limited to certain types of activities, such as religious organizations. In South Korea, younger women also said they had little time or interest in political campaigns, however, these same women expressed heightened interest just a short time later due to the country's economic crisis. In Zimbabwe, formal community participation increased slightly with parity, 5 to 6 percent of women said they participated in community activities at the time they became sexually active, compared with 10 to 11 percent participation after the birth of the fourth child. It may be that as women's status increases with motherhood, it becomes more acceptable for women to play a role outside the domestic sphere. Nonetheless, women who participated in formal community activities early in life tended to continue community activities

throughout their lives. Researchers found no link between contraceptive use and formal community participation between births.

**POLICY AND PROGRAM IMPLICATIONS** While providers have traditionally stressed the health effects of contraception, they should also understand that women see contraceptive benefits more broadly. Providers should be aware that women see family planning as something that affects them psychologically — by reducing their fear of pregnancy or by increasing their anxiety about side effects. In addition, women consider the effects of family planning on their domestic lives — whether smaller families will enhance or diminish their happiness at home. Also, providers should understand that some women link family planning use with work. Some women see smaller family size and reduced childbearing and childrearing responsibilities as opportunities to pursue paid work in the informal and formal sectors. Their work may serve as a vehicle for personal fulfillment or as a source of conflict as women try to balance household responsibilities and employer demands. Other women worry that contraceptive side effects may limit their ability to work inside and outside the home and therefore, are reluctant to initiate or continue contraceptive use.

Family planning policies and programs should expand information, education and communication efforts beyond messages about health. By offering clients a more comprehensive view of its effects on the multiple dimensions of their lives, family planning might become a more attractive option to some couples.

#### ***Gender norms strongly influence women's family planning experiences***

Unequivocally, across all WSP studies, women's experiences with family planning are strongly affected by societal constructs of femininity and masculinity. Gender norms and expectations influence every domain of women's lives — personal, domestic, economic, and community — and women and men play very different roles in each of these spheres. Gender shapes family planning experience by determining who has access to



*"The man of the house never likes it if the woman can't work. He says, 'Did I marry you to keep you as a pet? I married you to work in my house! If you sit around, who will look after the children, and who will do all of the chores?' This is why I stopped taking the pills."*

**Woman in rural Bangladesh**

reproductive health information, who holds the power to negotiate contraceptive use or to withhold sex, who decides on family size, and who controls the economic resources to obtain health services

Children learn the distinction between men and women's roles at an early age. In Jamaica, where adolescent pregnancy rates are among the highest in the Caribbean region, gender norms have created two distinct sets of reproductive attitudes and behaviors among young adolescents. Twelve year old boys viewed sex as pleasurable and fatherhood as a sign of maturity. "Them would big him up and say him a big man," said one boy when asked to describe the reaction of peers to the news a boy had fathered a child. Conversely, 12 year old girls spoke of sexual activity and unplanned pregnancy as forbidden, shameful and disruptive. "Them would call her *sketel* [slut]," one girl said, commenting on how peers would react if they learned a young adolescent female was sexually active.

In each WSP country and across age spans, separate roles ascribed to women and men translate into different responsibilities for contraceptive decision making. In a Zimbabwe study that examined social constructs of quality of life, some men were willing to give women the lead in decisions of family size, since "women are the pillars of the home" and the ones ultimately responsible for family welfare.<sup>10</sup> Although most Zimbabwean men believed family planning should be a joint decision, others were not so willing to share their control. "The husband always has the final say," said one rural man. "What happens is that women are limited in their thinking, and if you do not show your dominance, you will have problems."<sup>11</sup>

In focus groups in China, on the other hand, men tended to grant women authority in family planning decisions by default, saying that such matters are beneath the dignity of men, who are occupied with more important matters.

Except for day to day household concerns, Indonesian women sought their husbands' opinions on most decisions, including household finances and contraception. Women in Indonesia told interviewers that they often felt caught

between cultural expectations of wives' subordination to husbands and their need to work to support their family's economic needs. And in Mali, even husbands who supported family planning in principle emphasized that men are the primary decision makers in the home.

When traditional gender roles are challenged, the consequences for women may be serious. In WSP studies in Bolivia and the Philippines, study participants raised the issue of violence and its effects on their lives. Data from these countries suggest that in cultures where men have ultimate authority, their perceived loss of control — as exemplified by women's refusal of sex, for example — may result in verbal and physical abuse of women. In in depth interviews in El Alto, Bolivia, women explained the difficulties of refusing sex. As one woman put it, "I didn't want to have sex. Then he said I must want to be with another man." More over, all 31 male participants in the same study said they had either physically or verbally abused their partners, with half mentioning physical violence.

Similarly among women in the Philippines, 25 percent surveyed in Northern Mindanao said that husbands had physically abused them. Investigators found that husbands were more likely to be abusive if traditional gender roles had been altered, for example, if men were involved in child care or marketing for food, or if women were working for income. The same study showed that women's use of family planning — possibly indicative of increased autonomy and men's loss of control — was a factor in domestic violence against women, as was unwanted pregnancy.

Even where there is concordance on family planning decisions and women are encouraged to contribute economically to the household, they may have limited opportunities for rewarding, remunerative work outside the home. They may be poorly prepared for formal sector jobs (as was the case with adolescent mothers in Zimbabwe and Jamaica) or may be restricted to work in low paying jobs (as in the Philippines). They may be prohibited from inheriting wealth or obtaining credit (as in many African countries). In WSP research, gender norms, internalized by men and women alike, almost always required women to



*"If my wife makes the decision to use family planning without my consent, I would divorce her."*

**Malian man**

bear primary, and often sole, responsibility for children and home

Thus, family planning is one strategy that women have available to improve their lives, but gender norms play a major role in determining if, how, and to what extent women can take advantage of the opportunity it offers

**POLICY AND PROGRAM IMPLICATIONS** A woman's experience with family planning is likely to be determined by society's expectations of her multiple roles as wife, mother, and member of her community. To be effective, reproductive health policies and programs must, therefore, take this into account. Program planners might ask how women's domestic responsibilities influence the way they get health information and how they are able to access services. Programs might offer contraceptive services and information to women in the work place. Or, if men are viewed as the primary decision makers in the home, services that include counseling to promote gender balance in reproductive decisions could improve couple communication and possibly allow women greater household autonomy. Since most women value motherhood as an important — and often the most important — role in their lives, family planning messages must acknowledge this by highlighting the benefits of child spacing for the health of the mother and her children.

Nongovernmental organizations (NGOs), including women's advocacy groups, could play a key role in partnerships with health workers and policy makers, helping to make reproductive health more visible and better understood in the community and advising on how best to respond to women's needs and interests. In particular, women's advocates could help develop guidelines for gender sensitive programs that promote the concept that women and men can be partners in reproductive health. (The WSP is supporting the development of gender sensitive guidelines in Bolivia.)

While few family planning programs can afford to provide all the services women need, providers can recognize that women's health needs are multidimensional. Accordingly, programs can

collaborate with other agencies to develop referral networks for problems they are unable to address. For example, health workers can inform women of sources of help for domestic abuse, or provide information on women's legal rights, on prevention and treatment of sexually transmitted diseases (STDs), or on income generating opportunities in the community.



KAREN HA DEE FHI

*Women in Indonesia said family planning and smaller family size promoted financial security and family harmony.*

Policy makers and program managers are unlikely to find short cuts to gender sensitive programs, but by recognizing the links between gender and women's access to and use of reproductive health services, they may be able to reduce gender discrimination and, over time, modify programs so that they do more to empower women.

## **BENEFITS TO WOMEN**

***Most women and men are convinced that practicing family planning and having smaller families provide economic and health benefits***

Across cultures, women and men surveyed in the WSP identified two main benefits of family planning. Smaller family size leads to increased family income, and contraceptives give women respite from pregnancies that are too closely spaced. For many, these perspectives were shaped by the

absence of family planning. Study participants cited their own experiences before and after contraceptive use. Others based their views on observations of their neighbors and comparisons between those who used family planning and those who did not.

In China, generational studies indicated stark contrasts in life before and after family planning. In focus group discussions, women and men described the times before family planning as desperate and bleak, and the times after family planning as optimistic. "My parents had eight children," one 56-year-old woman explained. "My father died when I was 20 — there was no money for the doctor. Some siblings were given to other families. Having too many children — not only do the parents suffer, but also the children, with bad nutrition and bad housing conditions." Another 60-year-old woman spoke of having six children, five of whom survived. "At home, we had nothing to eat. It is hard to talk about and sad to recall." When questioned about the relationship between family planning and various aspects of their lives, more than 90 percent of survey respondents in North Anhui and South Jiangsu provinces said family planning helped them become more healthy, earn more income, and spend more time on their jobs. "Now our lives are improved," said one 34-year-old woman. "We have fewer gynecological diseases. We have better health education material."

Better health was often cited by women in Indonesia as a reason to begin contraceptive use. "I have had many children," explained a woman in Ujung Pandang. "I thought if I was not using contraception, I would have even more. I was concerned with my own health."<sup>11</sup> In Zimbabwe, one woman said she advised her daughter-in-law to space her pregnancies. "You have to plan ahead," she said. "You should not have another when one is still in nappies [diapers]. I tell her not to forget to take her pills be it morning or afternoon."<sup>12</sup> In Mali, one woman explained that she began using contraception "to have a rest. It's the first time that I have weaned one baby before having another."

Economics also was a strong motivator for many couples to use family planning. In

Bangladesh, one woman described her decision to undergo sterilization, "Having four children nearly made me crazy," she said. "I couldn't give them food and clothes. They wandered from door to door and were driven away like dogs. One day my son asked, 'Why did you give me birth if you can't feed me?'"<sup>14</sup> A 43-year-old woman in rural Indonesia said, "With fewer children, expenditures are low, so [the family's] welfare is guaranteed. You are economically well organized."<sup>15</sup> A man in Ujung Pandang said, "The phrase 'many children, more economic fortune' is out of date. Today, many children means lots of problems, lots of responsibility."<sup>16</sup> In Egypt, a study of women with unplanned pregnancies found that both men and women cited the high cost of living as their main reason for not wanting another child.

**POLICY AND PROGRAM IMPLICATIONS** Because so many women and men are convinced of the health benefits of family planning, program managers and policy makers might consider promoting family planning as a form of "health insurance" for women and their families. Because traditional gender norms dictate that the male is the chief financial provider in the family, educational campaigns on contraception could include improved economic status as a benefit for men and their families. Programs could also promote the relationship between contraceptive use and women's ability to participate in income-generating activities as a benefit for families.

***Family planning offers freedom from the fear of pregnancy and can improve sexual life, partner relations and family well being***

For many women, contraceptive use carries important psychological benefits, among them freedom from fear of unplanned pregnancy. This was most evident in Bolivia, where the focus of WSP research was women and gender. A study in El Alto found that among three groups of women interviewed (those who used the intrauterine device or condoms, those who discontinued contraceptive use for reasons other than wanting pregnancy, and those who had not used modern methods), all held similar views about quality of life, couple stability

and women's self esteem and decision making. However, current users had more positive attitudes about sex and said that contraceptive use had lessened their fears of pregnancy. Another study in Cochabamba, Bolivia, found that women who used modern methods reported higher levels of sexual satisfaction. In the same study, contraceptive users were more likely to have higher levels of self determination in decisions about their money and their appearance.

In Mali, women said their overall relationships with their husbands improved because they were not worried about pregnancy and because they had time and energy that would not be available to them if they had larger families. "Because you have free time to take care of your husband, you can see the affection is reborn," one contraceptive user said. In Zimbabwe, men recognized the psychological benefits of contraceptive use for couples. "It gives us time to enjoy our wives, especially when it comes to sex." Another man noted that women who cannot control their fertility may become depressed if they feel they are "being used as a human making machine."<sup>18</sup>

Study participants in other WSP countries also cited benefits of contraceptive use, including more time for themselves and their families. Studies in Cebu and North Mindanao, the Philippines, found women with fewer small children had reduced work burdens in the home. In Indonesia, women said that having a smaller family reduced the years a woman was involved in the care of small children and increased the amount of time she had to participate in community activities and work. In Zimbabwe, both women and men named family planning as an important factor in quality of life. Women said a benefit of family planning was more time for rest and leisure and more time to devote to children and husbands.<sup>19</sup>

In China more than 80 percent of women and men said family planning gave them more leisure time, as well as more time for work and education. However, the majority of couples said family planning use did not affect their marital relationships or their sex lives.

In the Western Visayas, the Philippines, contraceptive users were somewhat more satisfied,

overall, with their lives than non users. Users were more likely to share decision making with their husbands about women's work outside the home, travel outside the community, contraceptive use and childbearing. In Cebu, researchers found that each subsequent pregnancy during the eight year study interval had a negative effect on women's quality of life indicators, which included material goods, labor saving conveniences, maternal nutritional status and child well being.

**POLICY AND PROGRAM IMPLICATIONS** Family planning programs have long emphasized the health benefits of contraceptive use to women, and this should continue. In the future, programs also may want to consider promoting the psychological benefits of contraceptive use for women and men. Concern about diminished sexual pleasure has frequently been a reason for dissatisfaction with contraceptive methods, particularly male methods, such as the condom. However, family planning programs should also inform clients that many couples report enhanced relationships once the fear of unplanned pregnancy is reduced.

***Where jobs are available, family planning users are more likely than non-users to take advantage of work opportunities***

The most compelling evidence of the positive effect of contraception and lower fertility on women's employment status comes from WSP studies in the Philippines. Secondary analysis of data from the 1983 Cebu Longitudinal Health and Nutrition Survey indicated that women with fewer children had greater increases in earnings. Mean change in income for women with no surviving children born during the study interval (1983-91) was 2.3 times higher than that of women who had given birth to one or more children during the same period. The change in income in part reflects an increase in average hours worked, especially for women in the informal sector. Piece workers had the lowest gains (19 pesos per week) while wage earners in the formal sector had substantially higher gains — 63 pesos per week on average. The negative effect of child bearing on income was explained by lower wages and fewer work hours. (See Table 1, page 16.)



*"The phrase 'many children, more economic future' is out of date. Today, many children means lots of problems, lots of responsibility."*

**Man from Ujung Pandang, Indonesia**

**TABLE 1 Effect of Family Planning on Women's Participation in the Work Force**

Country	Study Title	Methods and Sample Size	Findings
Bolivia	Women's Participation in the Work Force Follow up of 1994 Demographic and Health Survey	Interviews with 816 women 62% of women who completed Demographic and Health Survey in La Paz and El Alto in 1994	Women working increased from 58% in 1994 to 64% in 1997 <ul style="list-style-type: none"> <li>Working for pay in 1997 was associated with being older (OR=1.03) <sup>†</sup> using a contraceptive method during the past 3 years (OR=1.54) not being pregnant (OR= .49) and working in 1994 (OR=2.69)</li> </ul>
Brazil	Comparative Study of the Impact of Female Sterilization on Women's Lives	Survey of 236 sterilized women and 236 non sterilized women	<ul style="list-style-type: none"> <li>Although only 12% of sterilized women attributed change in economic situation to their tubal ligation virtually all (97%) reported an improvement</li> </ul>
Egypt	Role of Women as Family Planning Employees in Egypt	64 focus group discussions with female family planning employees interviews with 19 program managers analysis of data on 19 610 family planning employees	<ul style="list-style-type: none"> <li>82 % of 19 610 family planning employees are women</li> <li>Percentage of women in family planning occupations varies from 48% (physicians) to 100% (nurses)</li> <li>In focus group discussions women expressed pride in family planning work but concern that employment conflicted with time required for domestic duties and personal needs</li> </ul>
Egypt	Social and Behavioral Outcomes of Unintended Pregnancy	Survey of 1 300 women who had an unplanned pregnancy between 1991 and 1993	Of 1 300 women who had unplanned and unwanted pregnancy <ul style="list-style-type: none"> <li>49% said the birth increased household expenses</li> <li>7% were forced for economic reasons to work after the birth</li> <li>4% quit working after the birth</li> </ul>
Indonesia	Family Planning Women's Work and Women's Household Autonomy	Secondary analysis of national sample of 4 617 women from Indonesia Family Life Survey in depth interviews with 20 women and 20 men	Compared to non users women using long term methods were 60% more likely to be working for pay and 40% more likely to be in the formal wage sector Use of short term methods was not associated with working for pay working in the formal sector or hours worked per week <ul style="list-style-type: none"> <li>In in depth interviews most women said they worked only to help their husbands support the family even when their own income exceeded husband's income</li> </ul>
Philippines	Cebu Longitudinal Follow up Study	Survey follow up to 1983 and 1991 Cebu Longitudinal Health and Nutrition Survey 2 779 women in depth interviews with subsample of 60 women	Significant increase in women working from 46% in 1983 to 77% in 1994 <ul style="list-style-type: none"> <li>Women with children under 2 in 1997 were less likely to be working for pay</li> <li>Women with 1-3 children earned approximately 1/3 times the earnings of women with 4-6 children and twice the earnings of women with 7 or more children</li> <li>Women working in the informal sector were more likely to increase earnings through longer hours of work</li> <li>Women in the formal sector were more likely to increase earnings through increased hourly wages</li> <li>In in depth interviews most women said they preferred not to work outside the home</li> </ul>

**TABLE 1 Effect of Family Planning on Women's Participation in the Work Force — continued**

Country	Study Title	Methods and Sample Size	Findings
S Korea	Impact of Fertility Transition on Women's Status and Participation in the Work Force	Secondary analysis of data on urban women from a 1991 national survey 1 093 women ages 25 29 and 644 women ages 45 49 2 focus group discussions with women	<ul style="list-style-type: none"> <li>• Women's participation in the work force has increased from 39% in 1970 to 48% in 1995 nearly all in urban areas</li> <li>• Women in focus group discussions say that family planning has increased opportunity to work outside the home</li> <li>• Only 29% of younger women currently work compared with 57% of older women</li> <li>• 84% of younger women who worked before their first birth quit jobs around the time of first birth while 70% of older women quit jobs around the time of first birth</li> <li>• Among women working outside the home 17% of the younger group and only 2% of the older group had professional technical or administrative jobs</li> <li>• Women were likely to continue employment after childbearing if they had professional technical or administrative jobs</li> </ul>
Zimbabwe	Impact of Family Planning on Women's Participation in the Development Process	National Survey of 2 465 women ages 15 49	<ul style="list-style-type: none"> <li>• Contraceptive use and work patterns are established early 17% of women using contraception at first sex were in the work force compared with 10% of women not using contraception at marriage 22% of users were employed in contrast to 14% of non users and at first birth 13% of users working for pay contrasted with 6% of non users There was no relationship between current work and current use of family planning</li> <li>• Although 62% of women in this sample reported contraceptive use only 32% were currently employed outside the home</li> </ul>
Zimbabwe	Mediating Effects of Gender on Women's Participation in Development	In depth interviews with total of 80 married women of higher and lower fertility married men and older women 8 focus group discussions from same population	<ul style="list-style-type: none"> <li>• Older women and married men expressed support for women supplementing family income but concern that employment outside the home leads to promiscuity</li> </ul>

† OR = odds ratio

Focus group discussions and in depth interviews with women in Cebu, however, revealed that women generally prefer not to work outside the home. This position in part reflects the poor working conditions for women and the increased domestic burden when productive activity competes with time women must still devote to practical household tasks. Most of those who worked said they did so because household income was inadequate to meet the practical needs of household maintenance and childrearing. The investigators concluded that family planning use does, indeed, have a positive effect on women's income, but not without costs to women who now have a longer workday.

Zimbabwe studies suggest that the timing of contraceptive use appears to influence later events in a woman's life. A national survey of Zimbabwean women's participation in development found that women who had started contraception early in their reproductive lives were significantly more likely to be working at the time of survey.<sup>10</sup> Yet, the strong tendency for women to delay family planning until they have had their desired number of children appears to put them at a disadvantage in the country's highly competitive job market.

In another study, Zimbabwean women and men associated both family planning and women's participation in the labor force with quality of life, but it was important for women to prove their fertility before using a contraceptive method.<sup>11</sup> Similarly, in depth interviews with Zimbabwean women who had been forced to drop out of school because of pregnancy documented their regret that lack of knowledge of, or access to, contraception had cut them off from the education they needed to pursue careers.<sup>12</sup>

The WSP in Indonesia found that, compared to non users, women who used long term methods such as sterilization, intrauterine devices (IUDs), and implants were 60 percent more likely to be working for income. Among working women, long term method users were 40 percent more likely than non users to work in the formal (wage) sector. However, use of long term methods was not related to the number of hours women worked.

In Bolivia, the 1997 follow up to the Demographic and Health Survey (DHS) found that among women in La Paz and El Alto, work outside the home was more common among women who were older, who were not pregnant, and who had used contraception in the past three years. The study found that the percentage of women working increased from 58 percent in 1994 to 64 percent in 1997. In Bolivia, this increased participation in the labor force grew out of necessity. Women began to work as unemployment rates increased for men and as rural residents migrated to urban areas.

While contraceptive use has created opportunities for women to take on new roles outside the home, it has not freed them from their traditional roles inside the home. In numerous WSP studies, women said they were responsible for housework and child care, even if they helped bring in income. These findings will be discussed later in this report.

**POLICY AND PROGRAM IMPLICATIONS** Health providers, women's advocates and policy makers could promote family planning as a vehicle to help women earn income for themselves and their families. These groups also could work cooperatively to help women better reconcile their roles as home makers and employees. Additionally, they could establish networks to help women refine and improve job skills, to help working women find child care, and to help homemakers, who may exit and enter the work force, obtain job training.

***Family planning helps women meet their practical needs and is necessary, but not sufficient, to help them meet their strategic needs***

In examining the impact of family planning on women's lives, one issue to consider is whether methods and programs help women meet practical needs and strategic needs. Caroline Moser, who has written extensively on gender, defined practical gender needs as those that help women and men carry out the roles and tasks they currently have, for example, earning a living. Strategic needs are those that help women and men achieve greater equity, for example, elimination of job discrimination to

help women and men have equal opportunities for work. Moser stressed that both practical and strategic needs occur in a “gendered” context, one in which women are often disadvantaged simply because they are women. Gender norms, Moser said, are those societal and cultural beliefs and practices that define roles, opportunities, and limitations for women and for men. They serve, all too frequently, to limit a woman’s access to power and control over her own life.<sup>23</sup>

In the WSP, women and men saw family planning not as an isolated event in their lives, but an ongoing process that helps them achieve desired practical goals. Decisions to use family planning were connected to other individual and family needs. For example, study participants said contraceptive use is a way to protect women’s health from the stress of too many and too closely spaced pregnancies. Family planning is a way to ensure that family size matches the family’s economic resources, a vehicle that allows women to obtain an education, participate in the work force or devote additional time to her husband and children, or a way to enhance the quality of the couple’s sexual relationship by minimizing the fear of pregnancy.

However, while contraceptive use has helped many individuals improve the quality of their own lives, it has done little to change existing gender norms. In Bangladesh, a massive nationwide campaign has increased women’s contraceptive use to 45 percent of married women, yet women’s isolation and subservience persist. In Mindanao, the Philippines, women who used family planning were more likely than non users to suffer domestic violence.

In Indonesia and China, where contraceptive use is widespread, traditional gender roles prevail, and women acknowledged men as the official head of the household and the primary financial providers. In South Korea, study participants reported that family planning had reduced the time spent in childbearing and childrearing, offering women opportunities to work outside the home. However, while husbands did help with domestic chores, women remained primarily responsible for housework. This was also the case in Mindanao and Cebu, the Philippines, where

women worked outside the home but the bulk of housework and child care remained women’s responsibility, increasing their work burden.

Family planning led to improvements in the economic status of individual families, and women’s contributions to household income afforded them more decision making power in some instances. But contraceptive use did not lead to gender equity in the work place. In Zimbabwe, women were pleased that family planning allowed them to participate in the labor force, however, with limited job opportunities for both men and women in their country, only 32 percent of women worked outside the home — similar to the percentage working in the mid 1980s.

As noted previously, some women said that family planning gave them the opportunity to participate in community activities, many of which were religious or related to community betterment. However, women also said they limited their activities to avoid conflict with domestic and work place responsibilities. For example, female family planning employees in Egypt said they supported women’s participation in political activities, yet most women said they themselves did not have time to join political activities. In Western Visayas, the Philippines, women and men supported women’s participation in community activities — but few women were community leaders or officers in political or economic organizations. In Indonesia, women said family planning gave them time for community activities, but women also said that decision making about what they could or could not do ultimately rested with their husbands.

**POLICY AND PROGRAM IMPLICATIONS** As WSP research illustrates, increased contraceptive prevalence does not automatically translate into gender or class equity. Women who use family planning may be empowered to control the timing and spacing of their pregnancies, however, they are not necessarily empowered in other spheres of their lives. They may use family planning but still suffer from domestic violence, still bear the dual burden of housework and work outside the home, and still find themselves financially dependent on others.



*“ I keep quiet. My husband is all I have. He brings us medicine when the children or I are sick, but I don’t ever ask him for medicine. I am a woman ”*

**Woman in rural Bangladesh**

In the long term, to help achieve gender equity, family planning programs and women's advocates can work collaboratively to link contraceptive services with programs that empower women in other areas of their lives, such as credit programs that help women start their own small businesses, vocational programs that help women gain job skills, or organizations that educate women about voting rights and political participation. Policy makers should encourage governments to take the larger step of rethinking and restructuring the health, economic and social policies that now limit women's opportunities.

In Cochabamba, Bolivia, the 25 percent of contraceptive users who said they were dissatisfied with their method blamed side effects. In Zimbabwe, one group of rural women in Chitsungo Ward said they preferred the less effective method of withdrawal to oral contraceptives because pills caused menstrual changes, headaches, weight gain and diminished libido.<sup>24</sup> And some Zimbabwean men said they would encourage their wives to discontinue contraception if side effects occurred.

While many contraceptive users said they were counseled about the possibility of side effects, the reality of menstrual disturbances, weight gain, skin blemishes and other problems often proved difficult to accept. As one woman from Mali noted even though she had been counseled that amenorrhea was a possible side effect of injectables, "to go all this time without seeing my period well, I wasn't really expecting that."<sup>5</sup>

Study participants' comments illustrated the struggle to find an acceptable family planning method. "The first time [I used family planning] was after the birth of my second child," said a mother of four from North Sumatra, Indonesia. "I used pills but I started bleeding so I stopped. After the third child, I tried to use the IUD. After four months, I started bleeding, and I expelled the IUD. Then I tried again to use my own [traditional] method. Finally, I decided to use the pill again. After five years of using it, I suffered from heart disease. The doctor said, 'You have side effects [in] your heart from using the pills. Please stop using the pills.'"<sup>6</sup>

Fear of side effects and even of sterility — whether based on fact or rumor — caused some women to avoid contraception altogether. This was true in Cebu, the Philippines, where nearly 40 percent of non users said they were concerned about side effects. In Mali, one non user explained, "A woman who lived with us, she used family planning. She fell ill and even had two operations. She has not had any more children. When I saw her experience, I was afraid."<sup>2</sup> And in El Alto, Bolivia, one man said he and his wife had reservations about using contraception because it was hard to separate rumor from fact about side effects and efficacy. "At times people tell us the truth, and at times a lie, and it makes us doubt the truth. Sure,



*Some women faced obstacles in using contraception, including husbands' disapproval and unwelcome side effects. Women in Mali discuss family planning.*

## **COSTS TO WOMEN**

***Contraceptive side effects — real and perceived — are a serious concern for many women, more than providers realize***

Contraceptive side effects, often categorized as minor by researchers and providers, are a major concern for many contraceptive users. For women who use family planning, side effects can be a reason for stopping or switching to a less effective method. For women who do not use family planning, fear of side effects can be a reason to never start. Both the perceived and actual impact of side effects can be detrimental to women's use of family planning. (See Table 2, page 22.)

at times I think of using those methods, but later I decide not to ”<sup>8</sup>

**POLICY AND PROGRAM IMPLICATIONS** Because side effects play such a pivotal role in women’s choice of methods, their decisions to start using family planning, and their decisions to stop, providers must address these concerns. Providers must receive additional training in how to manage side effects—for example, recommending that oral contraceptive users switch to another brand of pill if they cannot tolerate side effects, offering ibuprofen or estrogen to implant or injectables users who report heavy menstrual bleeding, or offering another type of contraceptive altogether. Providers also must counsel women thoroughly—what they can and cannot expect from contraceptive use. Information will help individuals anticipate how side effects may alter their daily routine, make an informed choice about the method that is best for them, counter persistent myths and rumors about side effects, and help women and men recognize what physical changes may be due to side effects and what changes may indicate a health problem.

To help women better understand the practical implications of method use, family planning programs might establish peer networks, in which long-time contraceptive users are trained to counsel new users. These women could relate their own experiences, explaining how side effects affected their everyday lives and sharing their coping strategies.

Finally, women’s concerns over side effects emphasize the need for continued research efforts to develop more effective contraceptive methods that have fewer side effects and are controlled by women.

***When partners or others are opposed, practicing family planning can increase women’s vulnerability***

Women who use contraception in communities where family planning has not become a social norm can face severe consequences. These women may be treated as pariahs. They may face ridicule and disapproval in their communities, disdain from relatives and friends, even divorce and

abandonment by their husbands. In Bangladesh, women who were the first in their village to use contraception faced ostracism by community members. A rural woman who sought sterilization described her concerns: “I talked secretly with eight or 10 women about this. Some of the women said, ‘If the elders find out about anyone having this operation, they will not let her live in the village anymore. No one will eat food cooked by a woman who has been operated on.’”<sup>9</sup>

In Mali, contraceptive use remains a relatively rare phenomenon, and clandestine family planning users faced discovery and reprisal by husbands. Clandestine users hid their pills, or kept contraceptives at a friend’s house or at work. One Malian woman said, “On holidays I am nervous. Each time he goes into the room, I tell myself he must have them [pills]. My heart beats faster.” Another woman, experiencing amenorrhea, feared her husband would realize she was using family planning. And another woman said, “I know what I am risking by using family planning, and I know the day he [my husband] finds out, it will end in divorce, but I am hiding it so he doesn’t find out.” Men were clear that clandestine use was a crime deserving of retribution. “If my wife makes the decision to use family planning without my consent, I would divorce her,” said one man. Another man said, “What is clear is that a woman who decides alone, without taking into account her husband’s opinion, deserves punishment.”

In Jamaica, contraceptive use by adolescent girls was seen as an indicator of sexual activity, which was forbidden at their age. One female focus group discussion participant explained that a young adolescent woman who uses contraception would be shunned by her peers: “They would say she taking it [the pill] ‘cause she having sex a lot of the time.” Another girl said, “Her friends would say them no want her in them company.”

In Bolivia, one woman described the physical abuse she encountered during contraceptive use: “He told me we were going to make love, and I didn’t want to, and he said, ‘Why is it that you never want to? Don’t I give you pleasure?’ then he started hitting me. I said, ‘Don’t hit me. Why do you want to force me like this?’ He kept

**TABLE 2 Perceptions and Experiences with Side Effects**

Country	Study Title	Methods and Sample Size	Findings
Bangladesh	Social Transformation in Bangladesh: An Ethnographic Study of Family Planning and Women's Roles and Status	Ethnographic study of rural residents of two districts: 139 males and 151 females; key informants	<ul style="list-style-type: none"><li>• Women often had negative expectations about side effects; a few had regrets regarding abortion and sterilization</li><li>• Some men were concerned that side effects would lead to financial costs and inability of women to work</li><li>• Side effects not always treated by providers</li></ul>
Bolivia	Impact of Men's Knowledge, Attitudes and Behavior Regarding Fertility Regulation on Women's Lives	Structured interviews with 630 randomly selected couples	<ul style="list-style-type: none"><li>• 20% of women interviewed were not using a contraceptive method and were at risk of pregnancy</li><li>• 22% who were not using a method cited fear of side effects or medical contraindication</li><li>• 10% of women interviewed believed that cancer and/or AIDS is caused by IUD; 6% by tubal ligation</li></ul>
Bolivia	Fertility Regulation and its Relationship to the Stability of the Couple: Sexuality and Quality of Life	In depth interviews with 3 groups of women: modern method users (36), discontinuers (33) and non users (32); and 31 men	<ul style="list-style-type: none"><li>• Qualitative data show persistence of myths and rumors about the ill effects of contraceptives</li><li>• Many users said they were not prepared for side effects and were unable to distinguish contraceptive side effects from unrelated problems</li></ul>
Egypt	Social and Behavioral Outcomes of Unintended Pregnancy	Survey of 1,300 women who experienced unplanned/unwanted pregnancy between 1991 and 1993	6% of women surveyed had not used contraceptives for fear of side effects, even though they wanted no more children
Indonesia	Family Planning, Family Welfare and Women's Activities	Survey of 931 women and in depth interviews with a sub sample of 16 women in Central and East Java	17% of women had experienced a health problem they associated with contraceptive use
Indonesia	Family Planning and Women's Empowerment in the Family	Survey of 800 married women (ages 30-45) and in depth interviews with 30 couples in Jakarta and Ujung Pandang	<ul style="list-style-type: none"><li>• Women were generally positive about the results of family planning, but for 30% in Jakarta and 27% in Ujung Pandang, side effects were a negative aspect of family planning use</li></ul>

**TABLE 2 Perceptions and Experiences with Side Effects — continued**

Country	Study Title	Methods and Sample Size	Findings
Indonesia	Reproductive Decision making and Women's Psychological Well being	Survey of 800 women 12 focus group discussions with women and men and 24 in depth interviews with women in South Sumatra and Lampung	<ul style="list-style-type: none"><li>• 69% of users were generally satisfied with their contraceptive methods but 31% reported health problems related to use</li><li>• In depth interviews revealed a tendency to change methods because of side effects</li><li>• 17% of users said they got insufficient information from providers</li></ul>
Mali	Impact of Family Planning on the Lives of New Contraceptive Users in Bamako	Prospective qualitative study In depth interviews 55 new users 32 never users focus group discussions married men older women experienced users	<ul style="list-style-type: none"><li>• Most method change and discontinuation by new users was due to side effects</li><li>• Among never users of contraception husband disapproval was a greater deterrent than fear of side effects</li></ul>
Philippines	Economic and Psychosocial Influence of Family Planning on the Lives of Women in Western Visayas	Survey of 1 100 married women (ages 15 49) 9 pre survey focus group discussions and 27 post survey focus group discussions (some included men) 36 in depth interviews 50 key informants	<ul style="list-style-type: none"><li>• 82 of 579 women surveyed reported experiencing health problems attributed to contraceptive use</li><li>• The main reason women in focus group discussions cited for not using contraceptives was concern about side effects</li><li>• In order of frequency the reasons women surveyed gave for choosing a method were effectiveness (52%) absence of side effects (30%) and convenience (24%)</li></ul>

hitting me. He put his hand inside my womb [to remove the IUD]. 'That's how your man wants you to have it,' he said. I was screaming. I don't remember anything else because I had already fainted."

These examples illustrate the great lengths to which some women will go to control their fertility. For many, contraceptive use involves a continual weighing of potential benefits and risks.

Disapproval for those who challenge traditional beliefs comes not only for women who use contraceptive methods, but for women who provide them as well. In China, women who used and distributed family planning during the early years of China's one child policy compared their work to the unpopular job of tax collection. One woman from North Anhui said, "Family planning work is the most difficult under the heaven. We don't mind working hard, but the worst thing is people don't understand our work." Many other past (and present) family planning workers said if a woman in China can succeed at family planning, she can succeed at anything. A family planning worker in Upper Egypt, where contraceptive use is not as widespread as in other parts of the country said, "The main difficulty is the feeling of insecurity when visiting households we do not know. Some men say bad words and some husbands and mothers of clients do not meet us nicely and quarrel with us if anything happens as a result of using contraceptives." Another family planning leader likened her work to "swimming against the tide."<sup>30</sup>

**POLICY AND PROGRAM IMPLICATIONS** Health providers should realize that new contraceptive users often do incur significant risks to prevent pregnancy. Contraceptive counseling should include questions that will help women not only evaluate the benefits and disadvantages of particular contraceptive methods, but also assess the emotional and



*" People said  
many things  
about my having  
the operation  
[sterilization]  
'Don't you stand  
next to us  
Stay away!  
Even to look at  
you is a sin!'  
I would just  
weep when people  
said those  
things to me "*

**Woman from  
rural Bangladesh**

social costs of contraceptive use. Thorough counseling and discussion may help women anticipate and cope effectively with partners' or community reactions.

Again, peer networks may also help women to cope with the emotional costs related to contraception. Referrals to experienced contraceptive users may offer support and advice for new users, helping them adjust to this important change in their lives. Women's advocates could work with health providers to establish these community based networks. Long time family planning workers might also share their experiences with novice workers in training sessions.

Where family planning is not the norm, educational campaigns should be carried out at many levels: national or regional media campaigns directed to men and women, information and patient education at service locations, and community based education for groups of women, adolescents and men at the local level.

***When women have smaller families, they may lose the security of traditional roles and face new and sometimes difficult challenges, including the burden of multiple responsibilities at home and work***

Traditionally, women have achieved status and influence through their roles as mothers and wives, often, this was their only avenue. In many cultures, a large family is viewed as a necessity to ensure the survival of the family line (particularly given high infant mortality rates), to provide labor to maintain the family farm or business, and to provide security in old age for the parents.

As child survival rates improve, the economic need for children has declined. The option of having a smaller family has become more attractive to many couples, and modern family planning methods offer a means to this end. In developing countries, women who have come of reproductive age since the introduction of modern contraception

some 30 years ago have been pioneers. They are the first generation of women to view childbearing as a choice, rather than to accept it as fate. For many women, this situation is positive, offering new opportunities for family harmony, economic security or personal fulfillment through work or community service. For others, the shift from traditional to new roles is negative, creating stress, confusion and unhappiness.

The most striking evidence of the conflict between old and new can be found in South Korea. In the early 1960s, the government established a national family planning program as part of its effort to encourage economic development. Contraceptive use became widespread, and the government encouraged a two child norm, precipitating a drop in fertility from six children per family in 1960 to 1.6 in 1990. Yet, while fertility rates fell, cultural values changed little. South Korea continues to have a strong patriarchal culture, where women and men have separate roles and responsibilities. Even now, women are seldom in positions of political or economic leadership.

In focus group discussions, women in their thirties and fifties discussed the relationships between family planning and work. Older women said that they had quit their jobs once they were married, whereas some younger women continued to work after marriage and childbirth. Older women, who adhered to the traditional roles of *hyunmo yang cho* (wise mother, obedient wife) appeared happier and had higher levels of self esteem than younger women. Younger women struggled to perform multiple roles (wife, mother, homemaker, worker), often without help or understanding from spouses or in laws. One younger woman said, "Many of the professional women I know have merged their dual roles successfully. But no one has escaped without personal sacrifice, inner struggle or conflict." Another said, "My number one priority is my career, then child, then husband. Frankly, sometimes I think I am part of an overlooked but particularly confused generation of women. I have discovered that career alone is not enough. Most of my friends want children, too. But my career is more important to me than my child. Kids are kids for just a couple of years."

In Egypt, where female family planning employees were surveyed, the women said their work had given them opportunities to learn, to travel and to contribute to their communities. Some women said that they had assumed a greater role in household decision making. However, the women also said they experienced stress in trying to find child care, do housework, and care for sick children. Some experienced harassment from community members who resented or disapproved of their work. And some women said their work outside the home brought them increased respect from husbands and children — but they also received criticism from family members when they worked late.

In China, women and men spoke of women's changing roles in the work place, and many said women's status has improved because of their economic contributions. However, the divisions of labor within the home fell along traditional lines. Women were expected to be responsible for child rearing and homemaking, even if they worked outside the home. Many women viewed their work as a way to make a better life for themselves, their husbands and children. One 29 year old mother said, "I have to work more to make more money for my son. I have to build a house for him and his wife and save for myself when I am old."

In Indonesia, nearly 68 percent of the 589 women surveyed in Central and East Java said they worked full time. However, when asked about responsibility for household chores, 78 percent of women said they were responsible for cooking, 50 percent for cleaning, 53 percent for child care, and 58 percent for laundry. In Northern Mindanao, women spent from three to five hours per day on household chores, in addition to their income generation activities.

In Zimbabwe, women said work was an avenue to personal fulfillment. Men supported women's income generating efforts but said women's role as mother and homemaker should remain their top priority.

**POLICY AND PROGRAM IMPLICATIONS** WSP studies show that declines in fertility have given women new opportunities, yet women do not

always view these opportunities as beneficial for themselves. Women may struggle with how to integrate amorphous non-traditional roles with well-defined traditional ones. For many, it is not an easy task.

Health providers probably can do little to help women reconcile old and new gender roles. However, providers can be cognizant of the multiple demands on women's time and provide health services in settings that are convenient to women (work sites, for example) at times that are convenient to women (after work hours or on weekends).

## **BARRIERS TO FAMILY PLANNING BENEFITS**

WSP study participants acknowledge that family planning use carries both advantages and disadvantages. While most women indicate that they want to control their fertility, they note that obstacles prevent them from doing so, thus limiting the benefits they derive from family planning. Women's perceptions of those obstacles are presented below.

### ***Social, political and economic barriers limit benefits of family planning for many women***

Throughout the WSP, study participants noted numerous benefits of family planning, including the opportunities it provided for women to improve their education and job skills, to enhance the family's financial security, or to improve the woman's autonomy and self-esteem. Yet, the impact of family planning on women's lives is restricted by the social, political and economic climates in which they live.

Imagine that a young woman from Bamako, Mali, an immigrant to El Alto, Bolivia, and an adolescent from Fortaleza, Brazil, all realize the value of family planning and initiate use of an effective method. Unfortunately, contraceptive use does not guarantee that social or economic opportunities will magically open for them. For example, many women in Zimbabwe said they adopted family planning after having a baby. For some, pregnancy interrupted their education, and they found it difficult to return to school.

In South Korea and China, national efforts to increase contraceptive use coincided with economic development. Consequently, family planning and economic prosperity were linked for study participants in these countries. In Zimbabwe, although contraceptive use has increased in the past decade, women's labor force participation remains unchanged at 32 percent, because economic opportunities within the country are limited.

For many women in Bolivia and the Philippines, work opportunities have increased but primarily in the informal sector where wages are low and hours are long (although flexible). Women migrating to El Alto because their husbands were displaced from mines or farms find themselves at a disadvantage when looking for work. They often do not speak Spanish and have few skills to compete in the modern economy.

**POLICY AND PROGRAM IMPLICATIONS** If a woman cannot read or return to school because she is too old or because policies prohibit mothers from attending school, if she does not speak the economically dominant language or is from an unfavored minority, if she has few marketable skills and no training opportunities, if she needs most of the hours in the day to complete household chores, if she is not well connected to individuals who can help her get a job, if she does not have transportation to work, and if she does not have child care, family planning by itself will not change these factors.

To deal with this dilemma, health providers and policy makers should consider offering family planning as part of a holistic approach to improve women's welfare. For example, family planning could be linked to activities that promote women's economic development, women's rights, or women's empowerment. Another route is to offer educational and vocational programs to help women, including those who have dropped out of school or out of the work force, develop job skills. Such comprehensive efforts could enhance the impact of family planning.

***The benefits of family planning are reduced when contraceptives are ineffective, used incorrectly or inconsistently, and discontinued early (before pregnancy is desired)***

The use of contraceptives should allow women and men to have the number of pregnancies they desire, at the times they desire. In practice, however, many couples do not achieve this ideal. Some couples' plans for a family are threatened by infertility or miscarriages. Others plan for one pregnancy but give birth to twins or triplets. Some couples have little choice of methods, cannot find a method that suits them, have method failures, or do not use methods correctly. Others run out of contraceptive supplies or cannot cope with side effects. Due to a variety of biological, personal and structural factors, true control over fertility is rare in both developed and developing countries.

In several WSP studies, researchers found that many women who use family planning do not always enjoy benefits, due to contraceptive failure or improper use. For example, in the Philippines, a WSP supported analysis of contraceptive failure in Northern Mindanao was conducted with 1,253 contraceptive users. Pregnancy rates were surprisingly high for all methods except tubal ligation and Depo Provera: condoms, 77, withdrawal, 47, the lactational amenorrhea method, 43, calendar rhythm, 32, IUDs, 20, pills, 19, Depo Provera, 9, and tubal ligation, 2.<sup>†</sup> These failure rates are much higher than have been found elsewhere, including in clinical studies. Researchers concluded that user failure probably accounted for a large proportion of the unplanned pregnancies.

In China, although contraception is widely available, the choice of methods was limited until recently, most women had access to sterilization or the steel ring IUD. Previous studies found a failure rate of 12.6 percent in the first year of steel ring use. In the WSP sponsored research, 8 to 25 percent of the female study participants reported a contraceptive failure. Many of these failures were in South Jiangsu province, where the one child family is more strongly enforced and where most

women (81 percent of the sample) use IUDs. In the focus group discussions, women and men also raised the issue of the steel ring's high failure rate. One young woman said, "Even when women use family planning, they worry about the efficacy of the method." Failure rates will likely be reduced as the Chinese family planning program switches to more effective IUDs.

Other WSP studies found that contraceptive benefits were minimized when methods were used ineffectively. In Egypt, 62 percent of the more than 1,000 women with an unplanned pregnancy reported that they became pregnant while using a contraceptive method, primarily oral contraceptives.

In Cochabamba, Bolivia, about two thirds of the 630 couples interviewed reported using a traditional contraceptive method, mainly calendar rhythm, at some point in their lives, only half reported ever use of a modern method. Twenty five percent of women reported using the rhythm method at the time of survey. However, only two thirds could correctly identify the days in which women are most likely to become pregnant. For their male partners, accurate knowledge was even poorer, with only half of the male rhythm users able to correctly identify the fertile period.

Research in Mali prior to the WSP found that discontinuation of modern methods was high. In a 1994 survey of 889 family planning clinic clients in Bamako, 31 percent had abandoned contraception at the end of their first three months of using a new method and 77 percent abandoned their method within 12 months. Some women said they could not tolerate side effects, for others, the cost of methods and time spent going to clinics was too great an obstacle. In depth WSP research explored women's experiences with contraceptive use and learned that there is typically little support for family planning among Malian men, and most new users said that if their husbands objected to the practice, they would stop. Negative social pressure, therefore, may predispose women to discontinue a method, especially when the women have anxieties about side effects.



*" My mother died  
in the delivery  
of her third child,  
of a hemorrhage  
The baby was alive  
but was buried  
with my mother  
Not even the  
midwife came  
because my family  
had no money "*

**Woman in  
South Jiangsu China**

<sup>†</sup> Since information on monthly failure rates was not available from the survey, the Pearl index was used. The Pearl index is defined as 100 times the ratio of contraceptive failures divided by the length of exposure to the contraceptive method, measured in woman years.

**POLICY AND PROGRAM IMPLICATIONS** Efficacy of contraceptive methods is important to women. However, many WSP study participants felt they could not rely on the methods they had chosen. Some were willing to sacrifice efficacy for diminished side effects. Others switched methods time and again, searching for a balance.

Health providers can help women meet their contraceptive needs by first offering a variety of methods, including male methods. National family planning programs should ensure that women and men have an array of choices — a central element of quality of care.

In addition, providers should emphasize correct and consistent use of contraception. Counseling techniques must involve two-way communication, in which clients are encouraged to repeat the instructions given by providers and to ask questions. A follow-up could be scheduled, in which nurses or village workers contact contraceptive users one to three months after they begin a method to learn if they have problems or concerns. Providers could work with local women's organizations to reinforce messages about correct and consistent use. Women's organizations could also disseminate information about side effects and strategies for coping, for example, through printed materials, theater troupes, radio clubs or other popular media.

***For some adolescents, pregnancy is wanted***

Most providers discourage adolescent pregnancy because it can bring health risks for young mothers and their infants, and also carries socioeconomic costs for young women whose educations are interrupted by a pregnancy. Yet, when motherhood affords women status and support from their families and communities, some young women may welcome a pregnancy early in life.

In Brazil, among the 367 teens seeking prenatal care at the adolescent clinic at the Maternidade Escola Assis Chateaubriand in Fortaleza, a significant percentage were adamant that their pregnancies were wanted. When interviewed at baseline, 51 percent of pregnant teens were married or living with a partner, and 46 percent said they wanted to be pregnant (although 61 percent said they would have preferred to delay their pregnancies).



*Motherhood brought increased self-esteem for adolescents in Brazil*

At baseline, 54 percent of the prenatal group said they were pleased when they learned they were pregnant, believing pregnancy would improve their relationships with family, friends and partners. When questioned about others' reactions, the majority said their families and friends were happy as well. Seventy-one percent of women said their partners were pleased, 56 said their mothers were pleased, 45 percent said their fathers were pleased, and 62 percent characterized their friends as supportive. At 45 days postpartum, self-esteem among the teen mothers had increased significantly, compared with women who had not carried a pregnancy to term. However, in spite of their generally positive attitudes, some 25 percent of the pregnant teens said they had attempted abortion after they learned they were pregnant. Researchers concluded that, in this setting, many adolescents do not see pregnancy as a negative event in their lives — nor do their parents, partners and friends. (Interviews conducted one year postpartum and postabortion, which have not yet been analyzed, may show different perspectives.)

In Zimbabwe, studies found that women's first sexual intercourse typically occurs at age 18 and marriage at age 19. There is little incentive for women to use contraception — and only 8 percent do so at marriage — because women are expected to prove their fertility soon after marriage. One man, interviewed in a focus group discussion, noted that delaying pregnancy could mean social scrutiny for a couple. "If a newlywed takes three to four years to conceive, in laws wonder whether the child belongs to their son or to someone else."

In the study of young adolescents in Jamaica, both boys and girls saw parenthood as a major responsibility, requiring emotional and financial resources. However, young people also revealed mixed feelings about pregnancy and how it might affect their lives. One girl commented that a pregnant teen "would feel happy in a way and sad in a way." Some boys said fatherhood might increase their status among peers.

**POLICY AND PROGRAM IMPLICATIONS** Health providers, educators, parents and others who seek to encourage adolescents to delay pregnancy may sometimes face an uphill battle. Curiosity, peer pressure, media images — all can encourage young people to become sexually active. Many teens who do become sexually active do not use contraception because they lack access to methods and services, they do not plan to have intercourse, or they see parenthood as a logical next step in their journey to adulthood.

Nonetheless, providers should continue to emphasize the fact that adolescent pregnancy can have negative health and socioeconomic consequences — for the individual woman and the larger society. Health risks can be greater for adolescent mothers and their infants, and a pregnancy can interrupt a young woman's schooling. Faced with the demands of motherhood, many women abandon their education and, thus, lose the opportunity to gain job skills.

Policy makers should increase the resources they allocate for adolescent health programs. Education programs for teens should encourage them to plan childbearing as well as other aspects of their lives, such as work and education. Older women and men who have been teenage parents

might be enlisted to counsel adolescents about the advantages and disadvantages of teen pregnancy. In addition, older women and men might also be able to work with teen parents, helping them improve their parenting skills.

Health providers, policy makers, community leaders, religious leaders, women's advocates and educators should work collaboratively to develop programs that will help adolescent mothers continue their education and refine their job skills after pregnancy. The Program for Adolescent Mothers, offered by the Women's Center of Jamaica Foundation, could serve as one model.<sup>31</sup> Established in the mid 1970s as a pilot project, the Women's Center now operates islandwide, providing education for pregnant teens, counseling about family planning and on-site child care.

In addition, programs should address the needs of adolescent fathers — who, while they may not be forced to drop out of school — may feel increased pressure to forego their education to provide financial support for their new families.

***Family members, particularly husbands, play a critical role in the quality of women's experiences with contraceptive methods***

Most women do not make contraceptive decisions alone; other family members are involved. This involvement may include joint decision making by a woman and her partner about contraceptive methods and family size. It may include a dictate from the male partner about what the woman can and cannot do. It may include conversations with female relatives, who offer advice and information based on their own experiences. Or it may include considerations about how another birth would affect the lives of current family members, especially children. (See Table 3, page 30.)

In Cebu, the Philippines, only 11 percent of the more than 2,200 women surveyed said they would not consult anyone when making a decision about family planning. More than two thirds said they would consult their husband, while 17 percent said they would consult a female adult relative. When asked who should make family planning decisions, 16 percent of study participants said the woman, 11 percent said the man, and 70 percent said it should be a mutual decision.<sup>32</sup>

**TABLE 3 Contraceptive Use and Family Relationship**

Country	Study Title	Methods and Sample Size	Findings
Bangladesh	Social Transformation in Bangladesh An Ethnographic Study of Family Planning and Women s Roles and Status	Ethnographic study of rural residents of two districts 139 males and 151 females key informants	Husbands views of family planning determine women s initial use and continuation or discontinuation
Bolivia	Impact of Men s Knowledge Attitudes and Behavior Regarding Fertility Regulation on Women s Lives	Structured interviews with 630 randomly selected couples	<ul style="list-style-type: none"> <li>• Women contraceptive users were more likely to have higher sexuality scores than non users (OR=1.66)</li> <li>• Women with higher sexuality scores had higher self esteem scores (OR=1.98)</li> </ul>
Bolivia	Fertility Regulation and its Relationship to the Stability of the Couple Sexuality and Quality of Life	In depth interviews with 3 groups of women modern method users (36) discontinuers (33) and non users (32) and 31 men	<ul style="list-style-type: none"> <li>• Women and men regardless of method and consistency of use believe contraception reduces the fear of pregnancy thus making sex less undesirable for women</li> </ul>
Brazil	Adolescent Longitudinal Study Social and Behavioral Consequences of Pregnancy among Young Adults in Fortaleza Ceara	Interviews 367 pregnant women ages 12-18 196 abortion patients ages 13-18	<ul style="list-style-type: none"> <li>• Pregnant adolescents expected pregnancy to have positive effect on relationships with partners family members and peers by 45 days postpartum the adolescent mothers reported significant improvements in their relationships with their mothers but a worsening in their partner relationships</li> <li>• Adolescents who had terminated their pregnancies expected less positive relations with partners (31%) family (15%) and peers (18%) by 45 days post abortion relationships with family members did not change but they had worsened with partners</li> </ul>
China	Impact of Family Planning on Women s Lives	Focus group discussions with women and men of 3 generations survey of 6 000 men and women case studies of 30 families	<ul style="list-style-type: none"> <li>• 80% of women and men said family planning increases time for leisure employment and education but does not improve marital relationships</li> </ul>
Egypt	Social and Behavioral Outcomes of Unintended Pregnancy	Survey of 1 300 women who experienced an unplanned/unwanted pregnancy between 1991 and 1993	<ul style="list-style-type: none"> <li>• For 16% unplanned birth had negative effect on marital relationship</li> <li>• For 17% the birth negatively affected ability to care for other children</li> <li>• 42% of husbands wanted the pregnancy</li> </ul>
Indonesia	Family Planning and Women s Empowerment in the Family	Survey of 800 married women (30-45) and in depth interviews with 30 couples in Jakarta and Ujung Pandang	<ul style="list-style-type: none"> <li>• 64% of women in Jakarta and 69% in Ujung Pandang have discussed family planning with husbands</li> <li>• 76% of couples in Jakarta and 79% in Ujung Pandang agreed on desired number of children</li> </ul>



**TABLE 3 Contraceptive Use and Family Relationship — continued**

Country	Study Title	Methods and Sample Size	Findings
Malaysia	The Effects of Family Planning on Marital Disruption in Malaysia	Secondary analysis of 2 Malaysia Family Life Surveys 1976 (n=1 262) and 1988 (n=1 867)	<ul style="list-style-type: none"> <li>• Contraceptive users were 56% and 60% less likely than non users to experience marital disruption</li> </ul>
Mali	Impact of Family Planning on the Lives of New Contraceptive Users in Bamako	Prospective qualitative study In depth interviews 55 new users 32 never users focus group discussions married men older women experienced users	<ul style="list-style-type: none"> <li>• Husbands are considered ultimate authority in reproductive decisions</li> <li>• Elder sisters and husbands aunts can intervene when husbands are opposed to family planning</li> <li>• Mothers in law have little influence on family planning decisions</li> <li>• Women whose husbands approve of contraception say family planning has led to more satisfying marital relationships</li> <li>• Clandestine users fear that discovery by husbands will result in divorce</li> </ul>
Philippines	Social and Economic Consequences of Family Planning Use in Southern Philippines	Surveys of 650 ever married rural women and 1 000 ever married urban women 6 mixed focus group discussions	<ul style="list-style-type: none"> <li>• 25% of all women rural and urban reported ever having been physically abused by a spouse</li> <li>• Significant socio demographic correlates of abuse were earlier age at marriage Catholic religion ever use of family planning longer duration of family planning use and unwanted pregnancy</li> <li>• Significant household correlates of abuse were lower household income wife working for pay and husband shaming household chores</li> </ul>
Zimbabwe	Consequences of Family Planning for Women s Quality of Life	Focus group discussions with 16 groups of women 3 groups of men	<ul style="list-style-type: none"> <li>• Both men and women said that family planning enhances quality of life when couples share more time together and have a more satisfying sexual relationship</li> </ul>
Zimbabwe	Mediating Effects of Gender on Women s Participation in Development	In depth interviews with total of 80 married women of higher and lower fertility married men and older women 8 focus group discussions from same population	<ul style="list-style-type: none"> <li>• Older women tend to favor large families and advise young women to delay family planning</li> <li>• Most husbands believe their role as providers gives them authority in reproductive decisions</li> <li>• Influence of mothers in law is secondary to that of husbands</li> </ul>

In West Java and North Sumatra, Indonesia, women said couples jointly made the decision to use family planning, although husbands were regarded as the head of the household, and few women used contraception without their husband's knowledge. For some women, contraceptive use was not an option if husbands did not approve. "I dare not do so [use contraception]," said a woman from North Sumatra. "My husband doesn't permit me to use contraception. It is okay like this, suffering besides, I am not brave enough, so I follow his advice. We have many children already. It is okay if we have another. My children are grown up, so there will be one among them helping."<sup>33</sup>

In Bangladesh, most women were totally dependent on husbands for financial support. Consequently, husbands' views of family planning were pivotal in their contraceptive use or discontinuation. Women feared that physical side effects would curtail their ability to work, something that would be unacceptable to the family's chief financial provider.

In Brazil, adolescent girls reported that their relationships with their mothers actually improved after their babies were born, but their relationships with partners deteriorated. Most teens believed that a pregnancy would improve their relationships with family or partner, but relationships with partners improved only among girls who planned their pregnancies. Conversely, aborting teens received little support from parents and partners for their pregnancies, friends, relatives, mothers and partners were the ones who typically recommended Cytotec and herbal teas to induce abortion.

In the Mali study, one of the surprising findings was that sisters in law were powerful allies for new contraceptive users, especially when husbands were opposed. Elder sisters in law were seen as authorities. "She accompanied me there [to the clinic]," one new contraceptive user explained. "My sister in law is aware," said another woman. "She intervened because of my son and then the twins I had. She asked me to use family planning. She told me not to stop [using contraception], to continue with it." Mothers in law played a less critical role than researchers expected. "As for my

mother in law getting involved, this only concerns my husband and me," one woman said. Although sisters in law were influential, husbands made the final decision about family planning, citing their role as the head of the house, religious beliefs, or fear that wives might become promiscuous.

In Zimbabwe, husbands' relatives often played an important role in decisions about family life, including how many children a couple should have. Older women advised daughters in law about contraceptive use and family size. Most mothers in law favored large families and said contraceptives should be used to space children or by women who already had large families. "I expect five children from my daughter in law to help increase the size of the family."<sup>34</sup> Daughters in law said they listened, but did not always heed the advice.

However, the influence of mothers in law was secondary to the authority of husbands in Zimbabwe. Husbands felt they should make final decisions on family size because in their role as providers, they bore the burden of economic support for the family, and because of gender norms that placed men in authoritarian positions. "If I want four children and my wife wants six, she has to listen to me because I am the one who supports the family financially. If I decide to have five children, this is because I know I can look after them. The husband is the head of the family, and the wife can never tell me the number of children she wants to have."<sup>35</sup>

**POLICY AND PROGRAM IMPLICATIONS** WSP results showed that family planning is often a family decision. Women, who often define themselves in terms of their relationships with others, make decisions about contraceptive use based on relatives' perceptions, as well as their own views.

An important step to improving women's reproductive health is the involvement of men. Policy makers should allocate additional resources for reproductive health education, for male contraceptive methods and male health programs, and for provider training. Health program managers could conduct campaigns to educate men about reproductive health and the role they can assume in family planning, whether using contraception

themselves, supporting their spouses' decision to begin contraception, or supporting their spouse while she is using contraception. Health programs should offer counseling to help men and women improve their communications skills. Men also should be educated about the health risks to women when pregnancies are spaced too closely, or when pregnancies occur before age 20 and after age 40. In urban areas, employer based education programs for men might be an option. In rural areas, community or village meetings could be a forum to promote family planning.

Education programs should be developed to reach older women and men, who are the parents of reproductive age children and who may encourage their adult children to have large families to perpetuate the family line. Because older women say they have more time for community activities, educational programs at sewing clubs, political meetings, or religious gatherings may be a vehicle for education about family planning's benefits. If better informed about contraception, older women might become advocates for child spacing within their families.

Family planning programs must also understand and address the needs of men and women who are not in long term stable relationships. Education and information campaigns may need to be different for married and unmarried men. For example, reproductive health programs for men in stable relationships might emphasize the economic benefits of contraceptive use for the family or the potential for improved family relationships. Programs for unmarried men might emphasize personal responsibility or the benefits of STD prevention that some contraceptives offer.

### ***Women reap fewer benefits if family planning is initiated late in reproductive life***

Although many women and men recognize the benefits of contraceptive use for spacing or limiting pregnancies, far fewer use contraception to delay early pregnancies. In fact, many women do not begin family planning until they have had all the children they want. Exceptions are in China, South Korea, and Indonesia, where government policy has made early family planning the norm.

WSP research in these countries shows that women and men expect contraception to begin early in a woman's reproductive life. However, even in Indonesia, where a national family planning program has been in place for more than three decades, a study in Jakarta and Ujung Pandang found that, while approximately 30 percent of women used contraception before their first birth, the number of users after first birth increased to nearly 50 percent.

Most WSP studies suggest that contraception typically does not begin before the first birth, often because of societal pressure on women to prove their fertility. In Mali, where contraception is available but not yet the norm, women saw family planning as a way to limit births once they have guaranteed continuation of the family line. "I don't want to begin until I have four children. Then I'll use family planning," one woman said. Similarly, a national survey in Zimbabwe, where nearly half the women of reproductive age use contraception, found that 59 percent of women adopted a method after having one child. Although almost all women in the four WSP Zimbabwe studies supported family planning, the older generation of women in focus group discussions and in depth interviews were emphatic that family planning should be used to space children but not to limit family size. "Young women should have more children before they start to use family planning," said one rural woman. "It is good to have a big family." Not surprisingly, women in the Zimbabwe survey found that higher parity afforded them more autonomy in family planning decision making, 12 percent of women said they participated in decisions to use contraception after first birth, compared to 39 percent who decided to use contraception after fifth birth.

Egyptian researchers studying unplanned pregnancy also noted that as births increase women have more interest in delaying or preventing additional pregnancies. The same dynamic can be seen in the Philippines, where women in Western Visayas who used family planning had slightly more pregnancies than contraceptive non users, and in Cebu, women reported using more effective methods once they reached their desired



*" I don't want to begin until I have four children. Then I'll use family planning "*

**Malian woman**

number of children. Brazilian women who chose tubal ligation began having children earlier — and had more children on average — than women who were not sterilized. For these women, the decision to end childbearing was clearly a reaction to current family size.

Despite the tendency of many women to delay contraception, there is evidence from WSP research that some do begin early and, in so doing, experience benefits that distinguish them from delayed users. Women may use different methods, switch methods to try to escape side effects, and temporarily discontinue methods when they want to become pregnant. Nevertheless, for these women, family planning remains constant — a strategy for achieving health and well being instead of a reaction to unplanned, or too many, pregnancies. A WSP study in Zimbabwe found that women who reported contraceptive use at first sex, at marriage and after first birth had lower fertility levels than non users.<sup>36</sup> Researchers tentatively concluded that women who use contraception early tend to continue family planning throughout their reproductive lives. The same study also showed that women who used contraception at first sex were more likely to be currently employed, suggesting that early and consistent family planning may contribute to women's strategic economic goals.

Studies in Brazil, Jamaica, and Zimbabwe revealed that younger women are aware of possible missed economic opportunities due to a too early pregnancy. In Zimbabwe, dropout rates among pregnant adolescents are high, and many do not return to school after the births of their babies. In Brazil, a group of young women who sought hospital treatment for incomplete abortion perceived their unplanned pregnancy as a threat to their education and their ability to earn money. In comparing young women who carried pregnancy to term with those who sought treatment for incomplete abortion, at 45 days postpartum or postabortion, school enrollment had declined from 50 to 30 percent — but two thirds of the

adolescents who terminated pregnancy remained in school. In Jamaica, young girls and boys, some of whom were already reporting sexual activity without contraception, said parenthood was a major economic responsibility, but 70 percent thought a girl should be allowed to continue her education after pregnancy.<sup>†</sup>

**POLICY AND PROGRAM IMPLICATIONS** Reproductive health providers need to be cognizant of the fact that in many cultures, women do not regard early contraceptive use as beneficial, since it delays a critically important event: motherhood. Throughout the countries in which WSP data were collected, women repeatedly told researchers that their roles as mothers bring personal fulfillment and joy, as well as the respect and approval of families and peers. For these women, the decision to space births or limit family size will come only after this first significant event has occurred.

However, family planning program managers and health workers should continue to emphasize that while contraception can be used to space pregnancies and to end childbearing, it also can be used to delay first pregnancy without adverse effects on fertility. Drawing on what women say they value, reproductive health messages should emphasize that women who postpone childbearing until their twenties are likely to be healthier and to have healthier babies. In addition, providers and policy makers should emphasize that use of family planning early in a woman's reproductive life may allow her to continue her education and gain job skills. While women in many cultures gain status through motherhood, and young women, therefore, are often eager to begin childbearing, reproductive health providers and educators may be able to temper this enthusiasm with information about the health and socioeconomic risks of too-early pregnancies, as well as the benefits of delayed childbearing.

In addition, formal education about family planning — which may include use of a modern



*“ Our children just arrive is all. At times, I feel so sad. He, too, says, ‘What are we going to do? God must want us to have more babies.’ So this is how it is.”*

**Woman in El Alto  
Bolivia**

<sup>†</sup> The small numbers of girls who return to school after pregnancy was the motivating factor in establishing the Program for Adolescent Mothers administered by the Women's Center of Jamaica Foundation. This program, which has helped more than 1,300 young women continue their schooling, is profiled in a WSP case study by Barnett et al.

contraceptive method or a decision to abstain from sex — should begin early in women and men's lives, before first sexual intercourse. Family planning should be emphasized as life planning for boys and girls and included as a component of reproductive health. Programs should not merely provide information on reproductive biology but provide training to help young people develop skills in decision making and communications.

Because many youth become sexually active while in school (or while they are school age), schools are logical settings for reproductive health education programs. To be effective, school health programs that include responsible sexual decision making should be developed and implemented in collaboration with community leaders, parents, religious leaders, health workers, educators and young people themselves. Special efforts must be made to reach young men and women who do not attend school or who drop out. For this vulnerable population, programs could be offered in churches, youth clubs, or community centers.

Educators and parents who encourage young mothers to continue their schooling will be contributing to women's chances for a stable economic future. Postpartum and postabortion counseling is an effective way to reach women in need of contraception, especially young women who have experienced an unplanned pregnancy.

## **SERVICE DELIVERY ISSUES**

### *Men often have the dominant role in family decisions but tend to be marginalized by family planning programs and services*

As advances in science and technology have fostered an increase in the number and types of contraceptive methods available for women, family planning programs have targeted their services primarily to women. Programs have seldom placed an equal emphasis on educating and involving men. While men continue to play a primary role in decision making in the family, they frequently do not have access to information and services that would empower them to make informed decisions about contraceptive use. Men's lack of involve-

ment in family planning programs discourages them from becoming effective contraceptive users or supporting their partners' contraceptive use.

In numerous WSP studies, participants cited family planning as women's responsibility. However, decision making on family issues, including family size, was viewed as the man's responsibility or, in some cases, as the couple's shared responsibility. In many countries, men were insistent that the final decision about contraception was theirs, in other cases, women said they did not want husbands involved. In Mali, men said that the decision to use family planning should never be made without the husband's consent.

In Indonesia, where the country's contraceptive prevalence rate is 55 percent, family planning use is routine for women but not for men. More than 60 percent of the 700 women surveyed in Jakarta and Ujung Pandang said they had discussed family planning with their husbands, and more than 80 percent said their husbands approved of family planning. However, fewer than 20 percent of women said they had asked their husbands to use a contraceptive method. More than 38 percent of women in Jakarta and 11 percent in Ujung Pandang said they would rather not have men involved in family planning.<sup>37</sup>

When asked if local family planning clinics provided services for men, more than 40 percent of the 600 women surveyed said they did not know. When asked how family planning clinics could involve men, women suggested that clinics provide more information, that clinics provide more services for men, that programs promote male methods, and that clinics offer special hours for men.<sup>38</sup>

Another Indonesia study found that husbands strongly influence their wives' use of contraception, but wives have the responsibility to decide which specific method to use.<sup>39</sup> In Central and East Java, 43 percent of the 720 women surveyed said they made the most recent decision about their contraceptive method, and nearly 28 percent said they made the decision jointly with their husbands.

In China, both male and female study participants said services for men were available at

local family planning clinics, and both said they would be comfortable if men and women received clinic services at the same time, in the same location. Fewer than 8 percent of couples in South Jiangsu province and fewer than 20 percent in North Anhui said the husband should have nothing to do with family planning. However, the nationwide family planning program has focused on women, emphasizing use of IUDs or female sterilization. In focus group discussions, men said family planning was the woman's responsibility, but one 32 year old man from South Jiangsu said, "I wish we had better methods for men."

In Zimbabwe, men saw themselves as "executive head of the homestead" and they wanted to be involved in family planning discussions — a view shared by their wives. When questioned about strategies that would improve family planning, women said they wanted counseling with their husbands.

**POLICY AND PROGRAM IMPLICATIONS** Family planning programs that do not include men ignore an important reality in women's lives: the role men play and the influence they have on women's reproductive behaviors. Women may make decisions about family planning and family size with their partners. In some cases, partners make the ultimate decision about women's activities.

Family planning programs should intensify their efforts to educate men — including efforts to provide men with correct and accurate information about contraceptive methods, their safety and efficacy. This could alleviate many fears, such as among men in the Philippines, who said that vasectomy might rob them of their strength. In Bangladesh, men were concerned that women who used contraception would suffer debilitating side effects, which would render them incapable of taking care of the home and family and which would cost money to remedy.

Health policy makers and program managers should consider ways to increase men's access to contraceptive methods, including condoms and vasectomy. In addition, policy makers, program managers and donors should promote reproductive health as a concept that applies to both men

and women and should encourage shared decision making. Employers could offer work sites as places where men could receive health information and services, a strategy that could also be used to increase women's access to contraception.

***Women are generally satisfied with family planning services but want more female providers, more emotional support, help with side effects, and more information on contraceptive methods***

Most WSP participants who used contraception support family planning, are pleased with the services they have received, and are satisfied with the methods they have chosen. However, women also say that the services offered do not always match their needs, including needs for a variety of methods, services close to home, information about contraceptive options, information about how to use methods correctly, and explicit counseling about side effects. Also, the same gender power dynamics that affect marital relationships often affect male provider-female client relationships, making women reluctant to seek services or to ask questions about method use.

In Indonesia, more than three quarters of the 900 women interviewed in Central and East Java said they were satisfied with family planning services. However, 20 percent listed several problems with service delivery, including distance to clinics, long waiting times, unfriendly providers, lack of access to desired method, unskilled providers, expensive services, and insufficient information.<sup>40</sup> When asked what additional information they would like to help them make contraceptive decisions, more than one third of women said they wanted information about side effects, while 23 percent wanted information about method safety and 21 percent about efficacy.

For many women, family planning motivational messages have been effective. Women understand the family planning concept, now they want the details. In Jakarta and Ujung Pandang, Indonesia, half the more than 500 women interviewed said they wanted more information about methods, while nearly one fourth said they wanted more time with the counselor.<sup>41</sup> In Zimbabwe, women said they wanted a greater variety of

contraceptive methods available to them. They also said systems for referral for counseling about side effects were poor.<sup>4</sup>

In Brazil, where contraceptive use is typically limited to pills and sterilization, women who had undergone tubal ligation generally were satisfied with their choice. However, regret was an issue for younger women. Women who had undergone the procedure before age 30 were more likely to be dissatisfied than older women. Researchers suggested expanding women's contraception options, but also stressed the need for improved counseling about the permanence of sterilization.

For some women, a major difficulty in obtaining contraceptive services was the encounter with an authority figure. Gender and cultural norms affected women's interactions with providers (and vice versa) and women's comfort in voicing their concerns. In Indonesia, a 44-year-old mother of four said she was unhappy with the "safari system" of family planning, in which health workers visited a village to provide methods but then left shortly thereafter, unavailable to counsel women about side effects. One woman said, "The acceptor had to take the risk. Protest? This is a village. It is not polite to protest."<sup>43</sup>

Some women felt intimidated by male health providers. Women in Bolivia said they often did not discuss contraceptive use with their husbands because they were too shy. For women who are reluctant to discuss sexual issues with their intimate partner, the difficulty in discussing sexual issues with a male provider, who may be a stranger, was multiplied. "I am afraid to talk to the doctor sometimes because there isn't an appropriate place to do so—to talk about our problems, or the illnesses," said one woman.

In Jakarta and Ujung Pandang, Indonesia, women said they would not accept certain services from male health providers. For example, 40 percent of women in Jakarta said they would refuse counseling from a male worker, while more than

half said they would refuse breast and pelvic exams, Pap smears, IUD insertions, STD diagnoses, or injections in the buttocks. More than half the

500 women interviewed suggested that clinics hire more female doctors, who tend to be in short supply in developing countries.

In addition, class and cultural differences complicated women's attempts to obtain family planning services. Women in El Alto, Bolivia, who wore the *pollera*, the traditional female dress of the Altiplano, were more likely to feel discriminated against in health facilities, researchers found.<sup>44</sup>

Women who received quality care—defined in terms of respect from providers and thorough counseling—were willing to travel long distances and pay for services if necessary. One Bolivian woman

described her favorable experiences at a family planning clinic: "I prefer to go there, even though it is far away, because they treat me kindly. They talk to me, they explain things—everything. And when I don't understand or don't know, he [the doctor] explains to me. I am thankful to this doctor because, even though it is far, other people do not treat me as he does. Even though I have to pay, that's okay."<sup>45</sup>

**POLICY AND PROGRAM IMPLICATIONS** For most women, experiences with family planning services have been positive. They are pleased with their access to contraception. However, the services offered are often driven by the availability of particular methods, government policies, provider skills, and staffing constraints, rather than women's actual needs. Family planning services for men are lacking, and services are rarely offered as part of a larger reproductive health program.

Based on study participants' comments, family planning programs should have more female providers on staff, more time for counseling and education, realistic counseling about side effects, and providers trained to manage side effects.



*"I prefer to go there,  
[to the family  
planning clinic]  
even though it is  
far away. They  
talk to me,  
they explain  
things. Even  
though I have to  
pay, that's okay."*

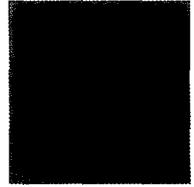
**Woman in El Alto  
Bolivia**

The structure and design of service delivery systems should be client driven, not provider driven. Providers must be sensitive to the multiple roles of women and cognizant that some men will oppose their partners' contraceptive use. Family planning programs must take the initiative to learn what clients want, then provide those services. The answers may not be radical or new—longer clinic hours, transportation to clinics, home based delivery of services, child care at clinics, female health workers, more counseling, and access to a wider array of methods. However, such efforts may be new for individual clinics.

An inexpensive way to discern client needs might be to enlist volunteers from women's groups to survey clients waiting for services. Or perhaps as important, volunteers could survey women in markets, at community meetings, in schools, or in religious organizations, some of whom may never go to clinics.

Information gained from these surveys could be useful, not only in shaping service delivery, but in shaping health policy as well. Analysis of results could be presented to policy makers with the aim of encouraging change in health laws and regulations, or encouraging them to provide additional types of contraception and other health services to best meet women's needs.

## IV. CONCEPTUAL FRAMEWORK



To understand better the impact of family planning on women's lives, the WSP staff developed a broad conceptual framework, which served as a tool for designing studies and analyzing research findings<sup>46</sup> The framework proposes relationships between family planning use and multiple domains of women's lives, in a context where external factors can affect both (See Figure 1, this page) This framework became a road map for planning projects as well as a compass for monitoring the direction of the work and conceptualizing the overall goals of the WSP

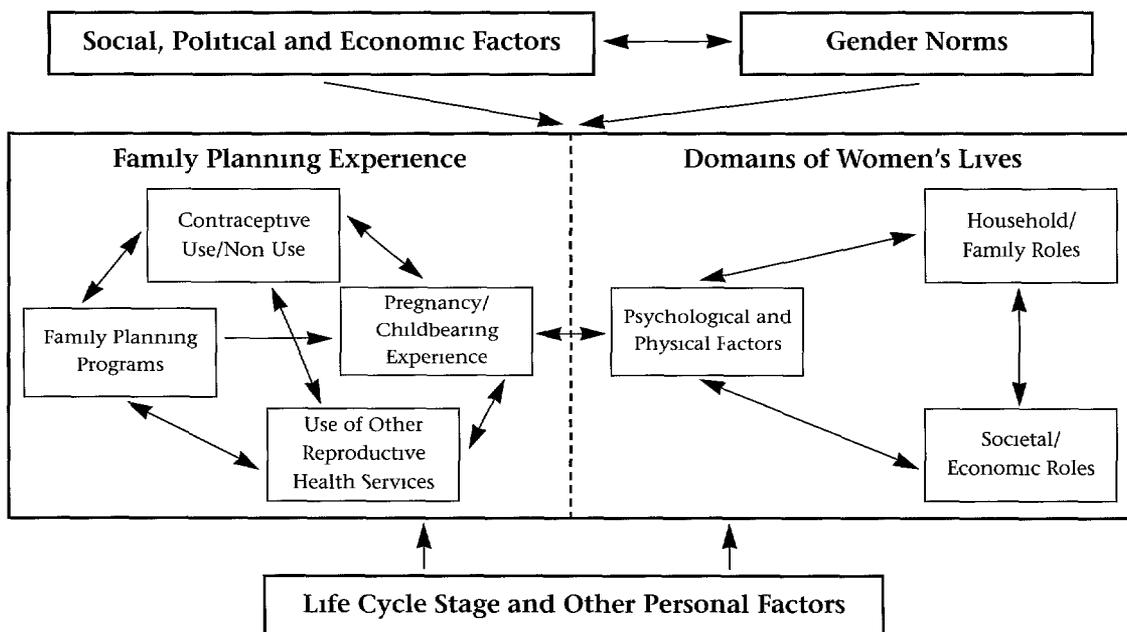
In developing this WSP framework, staff built upon their own experiences and the work of other

researchers in reproductive health, population, and women's studies, including

- *Oppong's framework on the seven roles of women*, which describes women's roles as individual, parental, conjugal, domestic, kinship, community and occupational<sup>47</sup>
- *The Hong Seltzer framework*, which is designed to examine the impact of family planning on six domains of women's lives: autonomy and self esteem, health status, family relations, public standing, educational attainment, and economic resources<sup>48</sup> This framework was USAID's original theoretical



**FIGURE 1 Women's Studies Project Conceptual Framework**



basis for the design of the Women's Studies Project

- **Schuler and Hashemi's framework on women's empowerment**, which presents women's sense of self and vision of the future, their status and decision making in the household, the ability to interact in the public sphere, participation in non family groups, mobility and visibility, and economic security<sup>49</sup>
- **Studies on quality of life**, which examine psychological status and well being, physical health, social interactions, and economic status<sup>50</sup>
- **J Mayone Stycos' model of the psychosocial consequences of contraceptive use**, which postulated short term positive and negative consequences of contraceptive use (diminished anxiety about pregnancy, increased sexual freedom versus anxiety about side effects, guilt and shame) on women's roles and their quality of life<sup>51</sup>
- **Women's perceptions of their reproductive rights**, developed by the International Reproductive Rights Research Action Group (IRRRAG) as the basis for an international study on women's perceptions of their reproductive rights and entitlement

The work of these researchers not only informed the WSP conceptual framework but also reinforced the need to develop a framework that 1) incorporates multidimensional and multidirectional variables, 2) recognizes that powerful external factors influence women's family planning use and its impact on the various domains of their lives, 3) considers family planning in the context of women's larger reproductive health needs, and 4) takes into account women's diverse roles in documenting their experiences with family planning

The starting point of the framework is women's experiences with family planning. This includes contraceptive use and non use, child bearing and pregnancy, family planning programs and other reproductive health services. Under this rubric, researchers asked women about their

perceptions of method availability and variety, method efficacy, quality of services, and decisions to start or stop contraceptive use

It is important to note that the mandate of the WSP was to study the impact of family planning, not the broader topic of reproductive health. In the WSP family planning was viewed as one component of reproductive health services. However, case studies did document women's experiences with integrated reproductive health services (See Appendix 3)

The WSP investigated interactions of family planning with various domains of women's lives, including their roles as individuals, as family members and as members of the work force and of the larger community. Researchers sought to understand how family planning affects women's psychological well being, whether it gives them more autonomy and increases their self esteem, how partners feel about family planning and how they affect women's contraceptive experiences, how family planning affects women's time for home and work tasks, and whether family planning improves women's participation and standing in the community

In examining the relationship between family planning experience and aspects of women's lives and analyzing study results, WSP investigators generally concluded that the impact of family planning is greatest on women's roles in the family and in the work place. Family planning has given women the opportunity to spend less time in reproductive (childbearing) roles and more time in productive (income earning roles) — a change that some women have accepted (China) and others have resisted (Philippines). Family planning also affects women as individuals, in some cases increasing their autonomy and self esteem (Bolivia). Yet, family planning has minimal impact on women's participation in community activities, and many women said community activities are not a priority for them, since home and work take up most of their time (Zimbabwe, Egypt)

In the conceptual framework, relationships between family planning and women's lives were explored in the context of three sets of external factors: (1) gender norms, (2) societal, political and

economic factors and (3) life cycle stage. Of the three external factors, gender norms emerged as a dominant influence during data analysis. The WSP would now redraw the framework to emphasize the tremendous impact gender norms have on both family planning experience and various domains of women's lives.

On the left side of the framework, researchers found that gender norms affect women's family planning experiences in multiple ways. For example, gender norms determine who makes decisions about family size, who makes contraceptive decisions within the family, if and when women contracept, and what opportunities are available to women when they are not restricted by childbearing and childrearing.

On the right side of the framework, gender norms determine, within a particular country, whether it is acceptable for women to define their own roles and goals and to participate fully in the educational, economic, and political system, whether women can move freely beyond their household, and whether they influence how money is spent or whether their children go to school. If gender norms are strong and traditional, as in South Korea, women may not see political or economic activities as attractive options. If gender norms are less traditional, as in the Philippines, the demarcations between the public and private spheres begin to blur and women gain more autonomy.

The conceptual framework was designed to help researchers explore the impact of gender norms on family planning and women's lives but



*“ My boyfriend  
had waited too long,  
so he wanted and  
I also wanted  
to experiment  
[with sex] I had  
tried to get some  
tablets [pills],  
but I was chased  
from the clinic,  
and I think it  
was because I  
looked very young  
at the time ”*

Zimbabwean woman

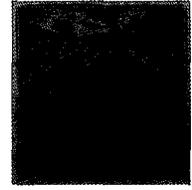
it also offers an opportunity to reverse the equation and examine the ways in which family planning practice affects gender roles. In terms of creating greater gender equity between women and men, change is slow. WSP researchers found Women — both contraceptive users and non users — are held accountable for the maintenance of their homes and upbringing of their children (and women hold themselves accountable). This is true even when women take on additional responsibilities in the work force or in the community. Data from Egypt, China, Indonesia, the Philippines and Korea provide examples. Women also remain the primary contraceptive users, the limited availability of reproductive health services for men and the few contraceptive method choices available to them

have further minimized the impact of family planning on this gender norm.

While gender was the most powerful external factor, the other external factors also affect women's family planning use and the domains of their lives, analysis showed. Political climates influence the acceptability of contraceptive use and the availability of methods (Bangladesh). Economic situations determined whether women can work or need to work to support their families (Indonesia, China, South Korea). Life cycle stage affects women's perceptions of whether they need contraception and their access to contraceptive services (adolescents in Brazil).

A description of how each study fits into the conceptual framework is included Appendix 5.

## V. LESSONS LEARNED FROM THE RESEARCH PROCESS



**T**hroughout the Women's Studies Project— from planning, through research, to dissemination — the WSP has sought

to involve researchers, policy makers/providers and women's health advocates. Each of these groups has an interest in women's reproductive health, and the WSP encouraged the active participation of these "stake holders" in all phases of the research process. This participatory and inclusive research process was labor intensive and expensive. However, WSP staff believe it enhanced the quality of the research by ensuring that the projects were locally owned. Following are lessons learned from the WSP, which may be applicable to future research projects on women.

■ **The research agenda should be locally defined**, with input from the triangle of researchers, policy makers/providers and women's advocates. This approach helped foster communication among these three key groups, helped ensure that the concerns of women, the primary users of contraceptive services, were heard and incorporated into the research agenda, and established a basis for practical utilization of research results to improve policies and services. Before research began, WSP staff sought to determine local interests by conducting in country needs

assessments to identify the concerns of diverse groups. Needs assessments became the basis for the WSP request for proposals, in country research concepts and individual subprojects.



*" Having four children nearly made me crazy I couldn't give them food and clothes They wandered from door to door and were driven away like dogs One day my son asked, 'Why did you give me birth if you can't feed me?'"*

Woman in rural Bangladesh

To strengthen the local network of researchers, policy makers and providers, and women's advocates, the WSP established in country Advisory Committees (IACs) in each emphasis country. This proved an effective mechanism for initiating and monitoring the progress of research and played a key role in determining how study results would be disseminated to improve services and policies. These advisory groups were involved in all phases of WSP supported research, from study selection to dissemination of findings. While this was advantageous, it also proved to be costly to establish and maintain.† One way to economize in the future might for a single in country Advisory Committee to serve multiple donors, thus expanding the IAC's scope of work beyond that of one project.

(See Appendix 6 for an overview of how the IAC worked in Bolivia and Indonesia.)

In country secretariats were effective liaisons between local researchers and WSP staff. In their role as local program managers, secretariats ensured that the goals outlined in the study protocols were

† Costs included domestic and international travel, honoraria, meals and meeting space, and the considerable time spent in selecting dates, inviting participants, and arranging for presentations at the meetings.

met, that the IAC meetings were held regularly and were well organized, that local concerns were addressed at IAC meetings, and that information dissemination plans were developed for local audiences. For example, the Philippines secretariat coordinated workshops on proposal writing, qualitative methods, data analysis and information dissemination. The Egypt and Indonesia secretariats organized national meetings to disseminate research results.

■ ***Women's advocates should be involved throughout the research process*** to ensure that the research project incorporates women's voices and reflects their concerns. Women's advocates can be involved in many ways in the research process, including advising on the scope and content of the research agenda, advising on study procedures, disseminating study results, and suggesting ways in which study results can be used to improve policies and programs. In the Philippines, for example, women's advocates helped identify sources of services that family planning clients might need, such as legal or social services. This information was included in a handout given to study participants by interviewers. Women's advocates also provided gender training to interviewers in one Philippines study.

■ ***Multiple research methods provide a fuller understanding of women's perspectives***. Integration of qualitative and quantitative methods often yields richer insights into women's experiences than the sole use of only one approach. In the WSP, both quantitative and qualitative approaches were important.

Since qualitative methods were new to many of the field investigators working with the WSP, technical assistance from FHI staff was especially important. This included help with focus group guidelines, instruction on use of text based computer software as well as compilation of a manual on qualitative approaches, and assistance on integration of qualitative and quantitative results in final reports. In Bolivia, for example, FHI staff provided training in the use of Ethnograph software for analysis of qualitative data.

■ ***Study participants' confidentiality must be paramount***. Explicit attention must be given to the protection of study participants' confidentiality and informed consent in social science studies. Whereas risks in a biomedical study may include physical risks (i.e., adverse reactions to drugs), the potential risks for participants in social science studies are typically emotional, social or economic. For example, an individual's reputation may suffer if others learn about domestic conflict, an out of wedlock birth or financial troubles.

Social scientists need to make greater efforts to ensure participant confidentiality, to inform study participants of risks (if any), and to ensure that study participants have given their informed consent to participate in the research process. This includes ethics training for interviewers and other study staff, including clerks who handle confidential questionnaires or transcripts.

■ ***Information dissemination should be part of the research plan and budget, not an after thought***. The impact of study results will be greater if information dissemination is considered early in the research process and planned in collaboration with researchers. By working together to develop reports, presentations and other materials, researchers and communications professionals can ensure greater accuracy in dissemination of scientific findings.

In addition to technical assistance on research methods, the WSP offered technical assistance in information dissemination. Many researchers had experience publishing in professional journals and giving talks to professional audiences but had not previously disseminated results to other stakeholders in reproductive health, such as women's advocates, family planning clients, employers, and community leaders. Researchers also had not routinely worked with the news media, which can be a key source of information for contraceptive users and potential users. WSP staff helped in country colleagues design and publish newsletters, press releases and short summaries of studies. Staff assisted colleagues in Egypt and Zimbabwe in developing comprehensive strategies for communicating study results both to technical and non technical audiences.

■ ***Study participants are an important audience for dissemination of research results***

To enhance opportunities for study participants to benefit from their experience, they should be considered an important audience for research findings. To share findings with participants while respecting their confidentiality is critical. One option used by colleagues in Zimbabwe, the Philippines and Egypt was to disseminate results through community workshops rather than to individual study participants.

The WSP is making a concerted effort to share findings with study participants and has encouraged colleagues to pursue creative avenues for dissemination to this group. An example is Jamaica, where copies of the case study on a

program for adolescent mothers were distributed to focus group participants. In Zimbabwe, plans are being made to discuss study results on the "Today's Woman" national television program, and audience members will include residents of communities where studies were conducted. In Bolivia, street theater has been used to disseminate study findings. In Egypt, researchers are considering disseminating study results at local immunization centers, which are well attended.

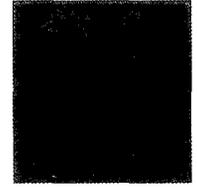
Sharing findings not only benefits study participants, but can benefit researchers as well. Inviting community members to offer comments can provide further valuable insight for investigators into the meaning of data and can validate study results.



*"With five children,  
is it possible for  
me to send them to  
higher education?  
Family planning  
helps someone like  
me whose salary  
[is that of] a lower-  
level civil servant."*

**Man in Jakarta  
Indonesia**

## VI. FUTURE DIRECTIONS



In almost all societies, women bear the major responsibility for the welfare of their families. It is not surprising, therefore, that most women desire some measure of control over their fertility. Yet, the extent to which women are able to turn their intentions into actions — to make reproductive decisions, to obtain services, to use methods effectively — and the consequences of those actions, vary according to the context of women's lives. Taking control of fertility through the use of family planning is one of many strategies a woman can employ to exercise autonomy in other aspects of her life. However, as the Women's Studies Project has shown, family planning decisions can have both positive and negative outcomes for women.

Women's reproductive intentions — desired family size, the timing and spacing of pregnancies — are conditioned by numerous sociocultural factors, including gender norms. Using many different voices, women participating in the WSP told interviewers that to attain their family planning objectives, they needed supportive partners, adequate information, unobtrusive methods, and respectful services.

The WSP was designed before the Cairo and Beijing conferences highlighted the paradigm shift from research on contraceptive use to research to improve women's reproductive health and gender equity. An important contribution of this Project is the provision of new data on women's perspectives, which can inform reproductive health policies and programs. While the WSP did not conduct cross country comparisons, future longitudinal studies could be used to explore how women's perceptions of family planning change throughout their lives.

The WSP found that women's collective and individual contraceptive needs are diverse and ever changing. In addition, findings suggest that women do not compartmentalize their needs, they see reproductive health as related, not separate, from other aspects of their lives. And women's early contraceptive decisions affect their later life. As providers and policy makers consider ways to improve family planning programs, they may want to consider the following questions raised by WSP research:

### ADDRESSING GENDER ISSUES

- Gender norms greatly affect women's access to reproductive health services and their use of contraceptive methods. What types of changes are needed in health programs and policies to make them more "gender sensitive?" What types of training are needed for providers?
- Men influence women's contraceptive experiences. How can policy makers and program managers educate men that family planning is a shared responsibility? How can policy makers and program managers educate men that they too, have reproductive health needs? How can providers make more services and methods available to men? What types of programs are needed to train health workers to provide comprehensive reproductive health care for men? How can programs help women and men improve their communications skills?

- Domestic violence affects many women and is sometimes associated with the use or non use of contraception. How can reproductive health programs and policies improve women's safety?
- Through use of family planning, increasing numbers of women are having fewer children and therefore, potentially more time for themselves. How might strategic interventions help to remove institutionalized forms of gender discrimination (in the home, work place or the political arena, for example) that prevent many women from realizing the full benefits of lower fertility?
- Some WSP studies attempted to capture information about women's community and political activities, given effective use of contraception. It appears that younger women especially have little time to devote to these areas. How then can women's participation in the broader community be encouraged?

## **IMPROVING SERVICE DELIVERY**

- As family planning programs evolve into reproductive health programs, how are women in different contexts best served? What do they want from new services? How should family planning, STD prevention and treatment, and prenatal care be managed, given constraints on staff time and resources? How will expansion to other reproductive health areas affect quality of care?
- In some countries, reproductive health services are not available to unmarried women. How can the service system be best expanded to provide age appropriate services to these women, given the cultural and political environment?
- Reproductive health services are often focused on maternal and child health care. How can programs be expanded to meet the needs of women who are not pregnant, including older women?
- Adolescents, whether sexually active or not, need counseling on their options for the future. How can they be encouraged to take advantage of educational and vocational opportunities? How can they be helped to see the long term consequences of their short term decisions?
- How can family planning programs accommodate the changing roles of women? How can programs reach women whose work burden is increased by responsibilities inside and outside the home? How can programs provide services for women who have little spare time?

## **IMPROVING EFFECTIVE USE OF METHODS**

- While providers have tended to minimize contraceptive side effects, women see them as a critical factor in determining which methods they will use, whether they will continue a method, or whether they even start contraception. How can providers become more attentive to these concerns? How can they be trained to counsel and treat clients more effectively? How can health programs meet the mandate to expand services to huge and increasing numbers of clients who need contraceptive services, but still address the concerns of specific individuals?
- Some WSP participants saw abortion as a remedy for contraceptive failure and were willing to risk unsafe abortions to end their pregnancies. How can health policies and programs prevent unsafe abortions? How can postpartum and postabortion counseling programs be strengthened?

While research findings are important, the WSP believes lessons learned from the research process can be useful as well for future projects. The process built upon the idea of partnerships. The model of the WSP triangle of policy makers and providers, researchers and women's advocates could be used or adapted to design research projects. In addition, the WSP triangle also could

be a useful model in designing health programs and policies. Collaboration among these three groups could provide a practical link among those who study population issues, those who provide reproductive health services, and those who use health services.

In the coming months, the WSP will continue further data analyses and dissemination. Many WSP investigators are still exploring quantitative and qualitative data from their studies, and their analyses and interpretations of findings will continue. A special area of focus for the WSP will be analysis of psychosocial variables in contraceptive use. At the same time, researchers will look further at the total synthesis of the WSP. Where subprojects in more than one country have data on similar issues, researchers will compare their findings — reanalyzing where appropriate — to investigate similarities and differences. Questions raised in one subproject are stimulating questions in another, leading to new paths of inquiry.



*“ Working in family planning is like swimming against the tide [But] this is what creates a leader because it needs great effort and strong character ”*

**Family planning leader in Egypt**

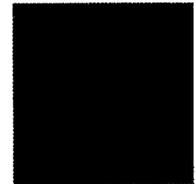
In the Philippines, future research will examine the relationship between family planning use and women’s economic well being. With funding from USAID’s POLICY Project, investigators from

FHI and the University of San Carlos in Cebu, the Philippines, will seek to better understand the economic impacts of various patterns of family planning use and childbearing on women throughout the life course. They will explore how these effects vary with gender roles and expectations, with women’s demographic and socioeconomic characteristics, and with changing employment opportunities and policies.

As the Women’s Studies Project concludes, investigators hope implications from research findings and lessons learned from the research process will extend beyond the 14 countries that participated directly in

the Project. We believe the conclusion of the WSP should not be the end of discussions on the impact of family planning on women’s lives, but the beginning.

## VII. RESEARCH FINDINGS



**H**ow does family planning affect women's lives? The WSP found that family planning reduces fear of unplanned pregnancy and affords women the freedom to enjoy sexual relationships more fully. It relieves women from the physical and financial stress of caring for a large family. It allows some to pursue an education and possibly gain a measure of economic security. And family planning gives women a means to avoid a pregnancy that, for them, may be too early in life, too late, or too soon following a previous birth.

But the WSP also found that family planning complicates women's lives. For some, when family planning is not an accepted religious or community norm, its use carries serious risks, including isolation, abandonment or physical abuse. Family planning use can create its own set of anxieties as women worry about physical side effects and whether those side effects will alter their ability to work, to care for their families, or to go to school. It causes stress as women maintain their reproductive roles but also take on new — and sometimes unwanted — productive roles in the work force.

Following are brief summaries of the individual WSP subprojects and findings on women's perceptions of the immediate and long term consequences of their family planning experiences. The summaries are organized by region and country. Table 4 presents some contextual data for each country in the study. Appendix 4 provides descriptions of individual studies and research methods, and Appendix 5 provides a summary of study results. (Nigeria, where secondary analyses were conducted early in the Project, and Cameroon, where the WSP supported the addition of questions to a larger research project, are not included.)

Because this is a synthesis report, the authors did not include full reports from each of the WSP subprojects. These reports contain extensive data from surveys, in depth interviews and focus group discussions. They are cited in the "References" section of this publication, and copies may be obtained from Family Health International as they become available or via FHI's web site <http://www.fhi.org>

### ASIA

#### **BANGLADESH FAMILY PLANNING AND WOMEN'S EMPOWERMENT**

The Southeast Asian country of Bangladesh has often been praised as a "family planning success story." In the past 30 years, there has been a dramatic increase in contraceptive use — from 3 percent in 1971 to 49 percent today — and a sharp drop in fertility rates — from 7 births per woman in the mid 1970s to 3.4 births in 1993.

Increases in contraceptive use and declines in fertility have been due, in large measure, to the national family planning program's comprehensive efforts to increase contraceptive knowledge and access. Traditional gender norms and the custom of *purdah* were accommodated within the service delivery system as the government hired nearly 30,000 female health workers to provide contraceptive services to women in their homes and villages. In this way, a new health paradigm was integrated with tradition.

The family planning program in Bangladesh has been studied widely, and some of this previous research provided the basis for two secondary analyses supported by the Women's Studies Project.

**TABLE 4 Country Data on Family Planning, Women's Status, Health, Income, and Population**

Country	Contraceptive Prevalence %		Total Fertility Rate 1996	Life Expectancy at Birth 1996	Female Literacy Rate 1995	Female Literacy Rate as % of Males 1995	Maternal Mortality Rate 1990	GNP/ Capita (US\$) 1995	Total Population (millions) 1996	Population Annual Growth Rate 1980-96	% Population Urbanized 1996	Average Age at First Marriage
	Total	Modern Method										
<b>Asia</b>												
Bangladesh	49	36	3.2	57	26	53	850	240	120.1	1.9	19	14.4
China	83	81	1.8	69	73	81	95	620	1,232.1	1.3	31	22.5
Indonesia	55	52	2.7	64	78	87	650	980	200.1	1.8	36	19.8
South Korea	79	70	1.7	72	97	98	130	9,700	45.3	1.1	82	25.4
Malaysia	48	31	3.4	72	78	88	80	3,890	205.8	2.5	54	na
Philippines	40	25	3.7	68	94	99	280	1,050	69.3	2.3	55	21.4
<b>Latin America and the Caribbean</b>												
Bolivia	45	18	4.5	61	76	84	650	800	7.6	2.2	62	20.0
Brazil	77	70	2.3	67	83	100	220	3,640	161.1	1.8	79	21.1
Jamaica	62	58	2.5	74	89	110	120	1,510	2.5	1.0	54	17.2
<b>Africa and the Middle East</b>												
Egypt	48	46	3.5	65	39	61	170	790	63.3	2.3	45	20.2
Mali	7	5	6.8	47	23	59	1,200	250	11.1	3.0	28	16.0
Zimbabwe	48	42	4.8	49	90	89	570	540	11.4	3.0	33	19.8

Sources: UNICEF Demographic and Health Surveys; the State Family Planning Commission Sample Survey of Women of Childbearing Age 1992; the United Nations Demographic Yearbook 1995; and the 1993 Contraceptive Prevalence Survey (Jamaica)

Ethnographic data collected from six villages in the Rangpur and Magura districts were the basis for both analyses. Researchers conducted in-depth interviews with 104 women and 92 men from these villages, asking them about reproductive decision-making and contraceptive experiences. In addition, researchers interviewed 47 women and 47 men in nearby hamlets.

In Part I of their secondary analyses, researchers concluded that the village-based delivery system of family planning methods had indeed been effective in increasing contraceptive acceptance, increasing contraceptive use, and reducing fertility in rural Bangladesh. However, "changes in reproductive norms do not constitute changes in gender relations."<sup>53</sup> Visits by female family planning workers to women in their homes may have reinforced women's isolation, subordination and economic dependence on men. "I keep quiet," said one study participant. "My husband is all I have. He brings us medicine when the children or I are sick, but I don't even ask him for medicine. I am a woman."

Home visits give women an easier alternative to visiting health clinics, yet in health clinics women might have access to a broader range of contraceptives and a wider array of reproductive health services. In spite of the number of female family planning workers — approximately 28,000 — women did not always receive services when they wanted them, especially services to address side effects.

Not only did side effects bring physical discomfort to the women, they sometimes brought negative reactions from husbands, who were concerned about women incurring costs for health care and not being able to work. One woman said, "My husband doesn't object to my taking pills. But when I get ill and he has to spend money, he snaps at me, 'You squander my money by taking these [pills]. Have I piled up money to spend on you?'"

In Part II of the secondary analyses, women reported that contraceptive use had brought economic benefits to their families, and a majority of women cited financial concerns as a primary reason for family planning use. Women also mentioned harmony within the home and relief from the physical stress of frequent childbearing as other

benefits.<sup>54</sup> "I will provide my daughter with family planning methods right after the birth of her first child and advise her not to have any more children for five years," said one woman. "Providing food for the family, keeping the house in shape and managing other expenses for babies will be easier for her if she has intervals between children." "

Women also reported negative experiences with family planning. For many, contraceptive side effects — whether real or presumed — were a source of anxiety and family conflict. In a survey of 104 women, 42 percent said they had experienced physical problems as the result of contraceptive use. "My husband became very angry and scolded me a lot when I became sick from using the Copper T [intrauterine device]. He told me, 'I won't take care of you if anything happens. If you want to adopt a family planning method, do it at your own risk.'"

## FINDINGS AND IMPLICATIONS FOR

■ **The role of female outreach workers could be changed so that they focus on providing a broader array of reproductive health services, on working with women in groups rather than individually and more generally, on helping to empower women.**

■ **Policy-makers and providers should help women make greater use of clinic-based services in Bangladesh. This strategy could improve the quality of women's reproductive health by making available a broader array of methods and services. Female health workers could accompany clients to health clinics.**

■ **Policy-makers should consider promoting micro-enterprise credit programs for women, such as the Grameen Bank, that link economic opportunities with family planning. Such programs could reduce women's financial dependence upon men while improving their knowledge of reproductive health and family planning.**

Women who began using family planning when programs were first introduced faced ostracism by family and community members. However, as contraceptive use has become the norm, some women are criticized for having too many children too quickly. For other women who practice contraceptive use against the wishes of family members, family planning use remains a source of anxiety.



KAREN HARDEE/PHI

*Older women in China said they regretted that family planning was not available to them when they were younger.*

### **CHINA: DIFFERENT GENERATIONS, DIFFERENT POINTS OF VIEW**

In China, there is a poster that hangs in shopping centers, markets, train stations and other public places. It depicts a child at the top of an escalator, and an adult at the bottom. The adult is saying, "I can't come up unless you come down." The adult represents China's economy and the child, its population of 1.2 billion people. The poster emphasizes the link between couples' reproductive and productive lives. The WSP supported a single study in China, which was funded by the Rockefeller Foundation, with an additional ongoing study funded by the Ford Foundation. No USAID funds were used for this research.

For Chinese couples, family planning occurs within the context of the government's one child policy. Implemented in 1979, the policy seeks to

lower the country's burgeoning population and, simultaneously, to improve economic conditions. Strong implementation of the one child policy, which was modified in some provinces to provide exceptions for rural couples with daughters, has caused a dramatic drop in fertility rates. In the 1950s, couples had an average of six children. Today, urban couples typically have one child, while rural couples have two. More than 90 percent of participants in this WSP sponsored study used contraception — either the IUD or sterilization.

Family planning also occurs within a cultural context that values male children over females. The desire for sons is strong, and couples with daughters are pitted. As one woman said, "My mother-in-law said it is inferior to have daughters. If you have a son, even your house will look higher." For couples who have daughters, family planning limits their status and their prospects for carrying on the family name. Sex selective abortion and female infanticide are two drastic responses to this situation.

The one child policy began at a time when the country's economy was beginning to grow, and its citizens had more freedom to pursue their own financial interests. Although they welcomed the opportunity to make more money, few people welcomed the idea of a one child family. Today, however, family planning is linked with both personal and national prosperity. Many residents are reconciled to the one child policy, and while the policy has undeniably had positive effects on China's economy, the government acknowledges negative consequences for individuals as well.

The WSP subproject in China examined the impact of family planning on women's work, education and quality of life. Research was conducted by the China Population Information and Research Center (CPIRC) in two counties in South Jiangsu province and two counties in North Anhui province. South Jiangsu, on the east coast, has a booming economy and strongly enforces the one child policy. North Anhui, in central China, is primarily agrarian, and enforcement of the family planning policy is more relaxed. In this study, researchers interviewed 1,996 women and 506 men. In addition, they conducted 56 focus group discussions with 220 women and 155 men, includ-

## FINDINGS AND IMPLICATIONS FOR

The State Family Planning Commission (SFPC) has recently begun a concerted effort to improve the quality of its family planning services. Based on study findings, the WSP researchers suggested several ways to enhance services and to add elements of gender sensitivity

■ Reproductive health programs should expand services to include young adults and older women, not just focus on women of childbearing age

■ The government and health programs should publicize the non economic benefits of family planning

■ Health programs should continue to provide Copper-T IUDs, newly introduced in China, as a more effective contraceptive option

■ Health programs should provide a greater choice of methods beyond the IUD and female sterilization

■ Family planning programs should provide contraceptive counseling for postabortion women

■ Family planning programs should involve and educate men, offering information and counseling about male sterilization as well as other aspects of reproductive health

■ Family planning programs should enlist the help of 'pioneer' family planning providers, whose experience and expertise would be useful in training current health workers

■ Mass media should promote the value of the girl child through a national education campaign that explains women's contribution to the economy, women's contributions in the home and to the family, and women's worth in their own right as individuals

ing older couples, reproductive age couples, unmarried women and men, and female entrepreneurs

In both provinces, family planning is now viewed as a fact of life, in spite of initial resistance "At the beginning of the family planning program people were not afraid of the sky or the earth," said one young man from North Anhui "They were most afraid of the truck with the loud speaker the family planning propaganda truck. But now it is much better. People are knowledgeable and accepting. Family planning is more regulated." In South Jiangsu couples have long accepted government policies, while in North Anhui, couples are resigned to them. Ninety five percent of women in South Jiangsu and 80 percent in North Anhui adhere to family planning policies, and most women say they are satisfied with their contraceptive methods. Among younger couples, family planning is seen as a societal norm while older women express regret at not having had access to contraception.

Older study participants equated large family size with economic burden, personal suffering and missed professional opportunities. One woman from South Jiangsu said, "My mother died in the delivery of her third child, of a hemorrhage. The baby was alive but was buried with my mother. Not even the midwife came because my family had no money." Another South Jiangsu woman said, "If family planning had been available earlier, my life would have been different. That is my life long regret. Because I had too many children, I had to quit [teaching]." Middle aged study participants said they were compelled to use family planning, yet they too saw family planning as a remedy for hardship. "We are relaxed in comparison to our parents," said one South Jiangsu woman. And the younger generation expressed a similar perspective that family planning would allow them professional advancement. "I'll marry but I don't want children for several years," said one man from North Anhui. "I want to accomplish something."

Family planning is considered a woman's responsibility, survey respondents said, although more than 80 percent of women and men in South Jiangsu and 70 percent in North Anhui said that services are available for men at local family planning



*"My husband became very angry and scolded me a lot when I became sick from using the Copper T. He told me 'I won't take care of you if anything happens. If you want to adopt a family planning method, do it at your own risk.'"*

Woman from rural Bangladesh

clinics. One man said, "Males take less responsibility for family planning. Men are important. Women should use family planning." In North Anhui, couples were more accepting of vasectomies and condoms—60 percent of men and women said husbands should accept vasectomy and more than 50 percent said husbands should use condoms—but contraception is still considered a female domain. The national family planning program reflects the view that women are the main family planning clients and promotes female sterilization and IUD use. In order to make contraceptive use more effective, the national family planning program provides quarterly "women's tests" (pregnancy tests and IUD checks), which are mandatory for women of reproductive age who are not sterilized.

In general, most couples in the survey were satisfied with their family size. In South Jiangsu, some 77 percent of men and women said they were happy with the number of children they had, the figure in North Anhui was 60 percent. The most satisfied were those with a son and daughter. Those who were unhappy said they had too few children rather than too many.

Although son preference is strong within Chinese culture, some couples said they would prefer daughters because their upbringing is easier for parents, less expensive (did not necessarily require schooling or building a house when the son marries), and daughters are nicer to parents as they age. In one county in South Jiangsu, study participants saw daughters as an economic benefit, their embroidery skills could add to the family income.

Nevertheless, son preference remains strong. Sons were viewed by most focus group discussion participants as "social security"—someone to take care of them in their old age, since daughters marry into another family. The desire for sons is so strong, focus group discussion participants said, that women sometimes go to great lengths to ensure that, if pregnant, they are carrying a boy. Ultrasound machines, which are used to check that IUDs are correctly in place, can also be used to detect a fetus' sex. A fetus of the wrong sex may then be aborted. This practice is illegal but continues nonetheless. "People use an ultrasound B machine," said one woman from North Anhui. "If it is a female fetus, they don't want it."

While sex selective abortion has been used to guarantee the sex of a child, it has also been looked upon as a remedy for unplanned births. Twenty-five percent of study participants (or partners) in South Jiangsu and 10 percent in North Anhui said they had undergone abortion, sometimes at the urging of their family planning cadre. Focus group discussion participants talked about high failure rates when using the steel ring IUD—a problem that should be reduced as China switches to the more effective Copper T IUD. (See Table 5, page 57.) In addition, 38 percent of women in North Anhui and 2 percent of women in South Jiangsu reported out of plan births (mistimed births or births in addition to the one or two child norm).

At the same time family planning use has become almost universal, women have begun to work outside the home for income. This had led to increased economic status for the family and greater autonomy for women in household decision making. One woman from South Jiangsu said, "My position is equal to my husband. I can spend money and discuss with my husband." Younger women also have had more opportunities for education than their older counterparts. Said one older woman in North Anhui: "Young women are in heaven, and we are on the ground."

Family planning, however, appears to have had little effect on marital or sexual relationships, with more than 90 percent of couples in both provinces reporting that contraceptive use made no difference in these areas. Ninety-five percent of couples in South Jiangsu and 74 percent in North Anhui said family planning had no effect on the quality or frequency of sexual activity. Couples appear to communicate about family size and family planning, perhaps because the government gives so much attention to the topic. When there is a difference of opinion between husband and wife, 40 percent of study participants said they discuss the issue until they reach a mutual decision.

In spite of the changes in the country's economy and in some women's individual status within the household, family planning has not affected gender roles. Women still maintain responsibility for domestic chores. Young people describe their ideal spouse in terms of traditional roles—the



*“ Young women  
are in heaven,  
and we are on  
the ground ”*

Older woman in  
North Anhui, China

husband as the breadwinner and the wife as the homemaker. A young woman from North Anhui said, "I want a career before marriage. After marriage, there is so much housework to worry about."

### INDONESIA CONTRACEPTION AND WOMEN'S QUALITY OF LIFE

Indonesia is the world's fourth most populous country with approximately 204 million residents in 1997. It is a geographically and culturally diverse collection of 10,000 islands populated by more than 100 ethnic groups who speak some 300 different languages. While the population is concentrated on a few islands, two thirds of Indonesians live in rural areas.<sup>55</sup>

The country's total fertility rate ranges from 2.7 on Java and Bali to 3.8 on other islands, with an average of 2.9.<sup>56</sup> Maternal mortality is high, the estimated ratio is 390 deaths per 100,000 live births, according to the most recent Demographic and Health Survey (DHS). Abortion is legal only to save the life of the mother. Although estimating the rate of illegal induced abortions is difficult, it may be as high as 20 percent of all pregnancies and is a major cause of death among women of reproductive age.<sup>57</sup> Half of all married women use contraception, and only 3 percent of contraceptive users do not rely on a modern method.<sup>58</sup>

The Indonesian Planned Parenthood Association was formed in 1957, and a governmental



**TABLE 5 China Pregnancies Resulting from Contraceptive Failure, According to Women and Men in South Jiangsu and North Anhui Provinces, 1996** (in percent)

Pregnancies due to contraceptive failure	South Jiangsu			North Anhui†		
	County A	County B	Subtotal	County C	County D	Subtotal
<b>According to women</b>						
None	80.1	61.8	70.9	91.0	90.8	90.9
One	14.3	24.6	19.5	7.9	8.8	8.3
Two or more	3.7	12.6	8.2	1.1	0.4	0.8
Never used family planning	1.9	0.9	1.4	na	na	na
Number of cases	(749)	(751)	(1,500)	(698)	(692)	(1,390)
<b>According to men</b>						
None	95.2	63.6	79.4	82.1	90.9	86.6
One	2.4	24.4	13.4	14.5	8.2	11.3
Two or more	1.2	5.6	3.4	2.1	0.4	1.2
Don't know	—	—	—	1.3	0.4	0.8
Never used family planning	0.8	3.2	2.0	na	na	na
Number of cases	(250)	(250)	(500)	(234)	(243)	(477)

Note: Percentages may not total 100 due to rounding.

† The data for North Anhui were calculated for women who had ever used family planning.

program was instituted in 1970. Coordinated by Badan Koordinasi Keluarga Berencana Nasional (BKKBN), the national family planning program focuses on community based services. It has a paid staff of 33,000 field workers and 500,000 village based volunteers supported by Ministry of Health medical clinics.<sup>59</sup> Family planning is practiced with government encouragement and in the context of

religious and gender norms that strictly define male and female behaviors.

The WSP supported four research projects in Indonesia. Each explored the impact of family planning on a different aspect of women's lives, including psychological well being, empowerment in the family, economic activity and family welfare. (See Table 6, page 59.)

## FINDINGS AND IMPLICATIONS FOR

**The benefits of family planning are well-recognized by women and men in Indonesia, and contraceptive use is high. However, method switching and discontinuation rates also are high, indicating that women are not always satisfied with the methods or services they receive. The research supported by the WSP in Indonesia has several implications for reproductive health policies and programs.**

■ **Indonesia's family planning program should strive to enhance the quality of its family planning services by offering a wider array of contraceptive methods and more information to clients on methods and potential side effects.**

■ **Providers and program managers should not equate women's silence with satisfaction. Women are often reluctant to express their ideas and concerns, particularly to male doctors, whom they see as authority figures. The national family planning program should encourage women to ask questions about methods and services. In addition, the program should attempt to recruit more female physicians since many Indonesian women mentioned this as important to them.**

■ **The family planning program should be targeted not only to women but should include men and should consider the addition of male methods. Because men play such a dominant role in women's decision-making, policy-makers should consider developing mass media campaigns that stress male responsibility in contraceptive use. These campaigns could encourage use of male methods, educate men about side effects of female methods, and encourage male support of women's contraceptive choices.**

■ **Although family planning helped women gain autonomy in some areas of their lives (such as control of fertility), in other areas they had little or no autonomy (control over financial resources). Providers, policy-makers and women's advocates can help increase gender equity in the home and work place by supporting women's reproductive rights and acknowledging women's multiple responsibilities at work and home.**

## Family Planning and Women's Psychological Well being

There has been little previous research in Indonesia on women's psychological well being. Consequently, an important first step in this WSP supported subproject was the development of psychological indicators. Researchers from the Atma Jaya Catholic University and the University of Indonesia conducted 12 focus group discussions with women and men to assist in developing indicators. Using 42 items derived from focus group discussions with women, researchers administered a survey to 800 women, then conducted 24 in depth interviews with women to complement the quantitative survey.

Study results show that contraceptive decision making among women from South Sumatra and Lampung is complex and occurs within the prevailing cultural, legal, and religious norms. Quantitative data indicated that women and men shared contraceptive decision making. Some 24 percent of the 298 women surveyed in South Sumatra said they decided jointly with their spouses about contraceptive use; the figure was nearly 44 percent among the 369 urban women surveyed in Lampung. Sixty four percent of the women in South Sumatra said they made the decision and their husband agreed, while 47 percent of women in Lampung gave this response. The in depth interviews, however, illustrated how women made contraceptive decisions in conjunction with their husbands. Men's wishes with regard to family size tended to prevail while women were responsible for selecting and using the method itself.

During in depth interviews, women described a range of benefits of family planning, including less stress and worry about family matters, more time with children and husbands, more time for work and community activities, and better health.

Having children was perceived as a woman's duty to her husband (according to Islamic religious law), and family planning was considered a woman's domain

Survey results indicated general satisfaction with family planning — only 7.9 percent of current users said they were not satisfied with their method. However, when questioned further, 20 percent of the 180 contraceptive users said they had experienced a "major" health problem related to contraceptive use, including headache, weight gain, amenorrhea, irregular bleeding or fatigue. Women noted that side effects often led to discontinuation or method switching.

More than 80 percent of contraceptive users said they were satisfied with the information they received when selecting their most recent contraceptive method. Women's positive responses, however, may not have been a reflection of women's own opinions but a mirror of "expected" views, influenced by the strong presence of the national family planning program, the wide spread acceptance of family planning, and the small family norm. Indonesian culture emphasizes politeness, and women's responses in the survey may have been more courteous than can be expected, researchers suggested.

When questioned about service delivery, more than 40 percent of women said they would like additional information on side effects, more than 30 percent wanted information on how contraceptives work, 17 to 29 percent wanted information on how the method affected their menstrual cycle, and some 20 percent wanted information about what to do if problems occurred.

Compared with non users, women who relied on either traditional or modern contraceptive methods felt more satisfied with their relationships with others and felt that they had more control over their reproductive lives, but they also experienced a higher level of role stress. Contraceptive use was not associated with more time for self and others, increased opportunity to attend to economic and social needs, less child care and fewer domestic responsibilities, less personal stress, increased vitality, or a more general satisfaction

with the overall welfare of their family. Survey results indicated that women's perceptions of the quality of their overall health were worse if they had experienced a health problem related to contraceptive use.

In addition to examining the impact of family planning, this study also explored the relationship of other factors, such as urban/rural



**TABLE 6 Indonesia Women's Perceptions of the Effect of Family Planning on Various Aspects of their Lives, 1996** (in percent)

Family planning has enabled me to	Central and East Java <sup>a</sup> (ages 15-49)	Jakarta (ages 30-49)	Ujung Pandang (ages 30-49)
Obtain more education	53.6 (n=499)	9.4 (n=351)	29.0 (n=207)
Be more efficient in my work	66.7 (n=621)	81.6 (n=87)	62.0 (n=208)
Earn more income	61.9 (n=576)	49.4 (n=87)	30.5 (n=177)
Have more leisure time	80.1 (n=746)	78.9 (n=323)	92.3 (n=259)
Spend more time in community activities	77.0 (n=717)	42.6 (n=326)	51.6 (n=256)
Take a leadership role in community activities	39.0 (n=363)	13.6 (n=309)	21.0 (n=22)

<sup>a</sup>Data from these two provinces collected in separate studies have been combined. Differences among the three groups may be due in part to the fact that these were not random samples. Data are not intended to be representative of all women in Indonesia.

residence and income generation, to psychological well being. Urban residence was positively associated with several aspects of well being, including less personal stress and more satisfaction with family welfare, but negatively related to the ability to attend to economic and social needs. Income generation was positively associated with attending to economic and social needs but led to more personal stress, less satisfaction with family welfare, and less time for self and others.

## Family Planning and Women's Empowerment

The relationship of family planning to women's empowerment was the focus of this study, which was conducted by the Women's Studies Center University of Indonesia, and included a quantitative survey of some 800 married women, ages 30 to 45, from Jakarta and Ujung Pandang.<sup>61</sup> Thirty women and their husbands participated in separate in depth interviews. Empowerment was defined as economic and social autonomy of women in the family. A secondary goal was to



*“There was an infection when I used the IUD, so I had it taken out. The doctor suggested I try the injection. I had spotting for a while, so I stopped using it after the third injection.”*

Indonesian Woman

assess, from the client's perspective, the extent to which the Indonesian national family planning program is gender sensitive and how family planning services could be improved for both women and men.

Family planning use was high among women in this study, as it is throughout Indonesia. The in depth interviews found that wives and husbands tended to agree on the need to use family planning for economic reasons. “[My wife is] using contraception because my income is insufficient,” said one man. “Contraceptive use frees my wife to work,” said another.

However, some women used family planning to maintain their own health or to have time to participate in community activities. Women and men voiced concerns about negative health effects of contraceptive use, and these concerns led some couples to adopt less effective traditional family planning methods.

While husbands were not generally involved in contraceptive use, most wives had discussed family planning with them. Nearly 64 percent of women in Jakarta and 69 percent of women in Ujung Pandang said they had asked their husbands'

opinions on family planning. Couples usually agreed on the number of children they wanted to have (76.3 percent agreement in Jakarta and 78.8 percent in Ujung Pandang), and most women participated in some type of community activity with the support of their husbands.

The majority of contraceptive users said family planning had no negative effect on their lives (68 percent in Jakarta and 71 percent in Ujung Pandang). Among those who did report problems, the most significant was side effects, noted by 30 percent of women in Jakarta and 27 percent of women in Ujung Pandang. Very few women spontaneously named any negative effects of family planning on their husbands.

In both Jakarta and Ujung Pandang, men were more likely than their wives to work and to contribute most or all of their income to the household. The division of labor in the household fell along traditional gender lines, with women (or persons other than the husband) doing most of the housework including cooking, cleaning, washing clothes and caring for children. However, men said they sometimes performed household tasks to “help” their wives. “Women are more tired than men. They look after children, wash clothes and dishes, prepare meals for us and the children,” said one husband. “I realize that, so I help her by washing clothes.”

Less than half the women surveyed worked for income, in Jakarta, only one quarter of the women worked, and these women had asked their husbands permission to work. The women most likely to say they wanted to join the labor force were younger women who were more likely to use family planning.

In depth interviews found that some women had economic autonomy in decision making regarding daily expenditures (but not necessarily large expenditures). Still, many women said they had to account to their husbands for how they spent money. Women, even those who earned their own income by working, tended to put their families' needs before their own when allocating economic resources. “It is me who receives the household income,” said one woman. “My husband only has his own money for cigarettes, which

sometimes is bigger than for household expenses. But if I want to buy something for myself from the savings from household expenses, I have to ask him first. I do the same for the children." Another woman said, "Yes, you could say I am free to spend the household income, but I myself do not have many personal needs. What I am thinking about now is how can we have our own house, how can I give better education to my children. Hence, I have to be disciplined."

Women and men reported high levels of harmony within the home. In the survey, women in Jakarta and Ujung Pandang said communication between husbands and wives was open and free, although men were the dominant decision makers. Women said that they could discuss many aspects of life with their husbands. Women indicated in the survey that they thought their opinions were valued by their husbands, and in the in depth interviews, many women (and men) described a home environment in which husbands were consulted on most activities. One woman explained, "everything I want to do I have to ask his permission. I cannot decide everything for myself. He will be angry." A man said, "Some times, if I feel uncomfortable with her idea, I won't let her do it."

### **Family Planning, Women's Economic Activity and Household Autonomy**

The research questions examined in this study were 1) What is the effect of family planning on women's labor force participation? and 2) What is the effect of family planning and labor force participation on women's household autonomy? Researchers at the Demographic Institute, University of Indonesia, defined autonomy in the household as the extent to which women have access to and control over maternal and other resources, their ability to make decisions about household and family matters, and their ability to participate in activities outside the house such as community organizations.

Researchers conducted a secondary analysis of the 1993 Indonesian Family Life Survey (IFLS) looking at 4,617 married women ages 15 to 49. Since the IFLS did not provide information on the relationship between women's work and household autonomy, in depth interviews were

conducted with 16 women, and separately, with their husbands, in West Java and North Sumatra. In addition, interviews were conducted with one male and one female community leader from each province.<sup>6</sup>

Analysis of the IFLS data showed that family planning only partially explained variation in women's work status. Use of long term methods (sterilization, IUD, or implants) was positively associated with working and work in the formal sector. However, use of short term methods was not significantly associated with any of the three work status outcomes (working/not working, working informal sector/working formal sector, or number of hours worked).

A number of background variables, however, did help to explain women's work status. Women who were over age 35 did not have children under age six in the home, and had a high school education were most likely to work outside the home. Education played a strong role in determining whether women worked in the formal or informal sectors. Women who had at least a high school education were 12 times more likely to work in the formal sector than were women with no education or only some primary school and were likely to work fewer hours per week. The husband's education was not associated with whether a woman worked or how much she worked.

When individual women and men were asked about family planning use in the qualitative part of this study, they expressed general agreement with the practice and spoke of its benefits. However, they did not link family planning and work opportunities.

In the interviews, both husbands and wives said that the household economy (and family survival) was the responsibility of the husbands.



*"I have had many children. I thought if I were not using contraception, I would have even more. I was concerned with my own health."*

**Woman in Ujung Pandang, Indonesia**

Women who worked — even those with higher incomes than their husbands — said they did so only to “help.” Many women stated that they worked because their husbands’ incomes were not sufficient to cover the family’s needs for food, clothing, and education.

The presence of a young child (or children) and related child care duties absorbed much of women’s time, regardless of family planning or work status. Women who worked outside the home said they were still responsible for being good mothers, serving and obeying their husbands, and doing the housework. Women’s autonomy in decision making and control over resources were not related to their family planning or work status, and work status did not release women from their domestic duties. “The primary duty of a wife is to serve the husband,” one man said. “Cooking first, then after that, washing the clothes.” A woman from North Sumatra said, “The husband’s tasks are outside the house, while the wife’s tasks are inside the house. Taking care of the children and the husband, this is the contract!”

Although some women gained status as a mother or by contributing to household income, women still remained subordinate to men. There were multiple instances in which women had autonomy in one aspect of their lives, such as in making decisions regarding routine household affairs, but remained relatively powerless in another, such as control over labor.

While family planning did not increase women’s perceived household autonomy, it did help couples achieve a small family size, and thus freed women’s time for activities other than child care. Having fewer children helped couples stretch money for food, health care and educational expenses for their children. Family planning use and the employment of women helped women and couples with their household survival strategy.

### **Family Planning, Family Welfare and Women’s Activities**

This fourth Indonesian subproject, conducted by the Population Studies Center, Gadjah Mada University, included a survey (931 women from two urban and two rural sites in the provinces of Central and East Java) followed by in depth interviews (with 16 of these women) <sup>63</sup>

Quantitative analyses of the survey data showed that family planning and lower fertility had only a modest effect on women’s social and economic activities and on family welfare. However, during in depth interviews, most women gave family planning credit for improving their lives. Most women said they used or had used family planning, and few had more than three children. Due to BKKBN’s successful efforts, the small family norm has become accepted by the majority of Indonesians, and fertility has fallen considerably. Since the use of family planning was widespread before most of the women in this study entered their reproductive years, they did not witness a dramatic change in their lives due to family planning — family planning had already been accepted as a social and cultural norm before they and their husbands were faced with reproductive decisions.

Most women were hesitant to criticize family planning, but some said that family planning had a negative effect on their lives because of contraceptive side effects. Even women who were supportive of the concept of family planning and spoke of its benefits complained of side effects, which ultimately led many of them to discontinue or switch methods. One woman described her experiences: “There was an infection when I used the IUD, so I had it taken out. The doctor suggested I try the injection. I had spotting for a while, so I stopped using it after the third injection.”

When asked about problems in obtaining family planning services, more than half the women surveyed said clinics were too far from their homes. Nearly 20 percent said long waiting times were a problem, while 18 percent cited unfriendly providers as a concern. When asked for their suggestions on clinic improvements, the majority (78.6 percent) did not offer an opinion. Among those who did, suggestions were for more information about side effects (39.7 percent), clinics closer to home (35.3 percent), more staff (21.3 percent), lower costs of services (19.9 percent), more time with providers (14.7 percent) and the availability of more methods and services (11 percent).

Women’s views of adequate family welfare were being able to supply the basic needs for food, clothing, and housing. Women also



*“ She is not free to decide everything by herself. She has to ask my permission. She can’t ever make any decision without permission, although she may think the purpose is good.”*

**Man in Jakarta  
Indonesia**

thought parents should be able to send their children to school to get a good education. In addition, the family should exist in social harmony — harmony between family members and with the community.

Women mentioned family size as affecting family welfare, but they also stressed that other factors were important. They recognized that limiting the number of children might lessen women's household chore burden and lessen the family's economic burden, but small family size was less important to women's perceptions of family welfare than financial factors.

Most working women in this study were small scale entrepreneurs (41.1 percent), laborers (30.7 percent), or farmers (12.1 percent). The ability of these sectors to absorb women as workers is affected both by limited supply of work opportunities and low qualifications of women workers (as indicated by educational level). Researchers concluded that women's employment was more related to opportunity and economic necessity than to family size and contraceptive use.

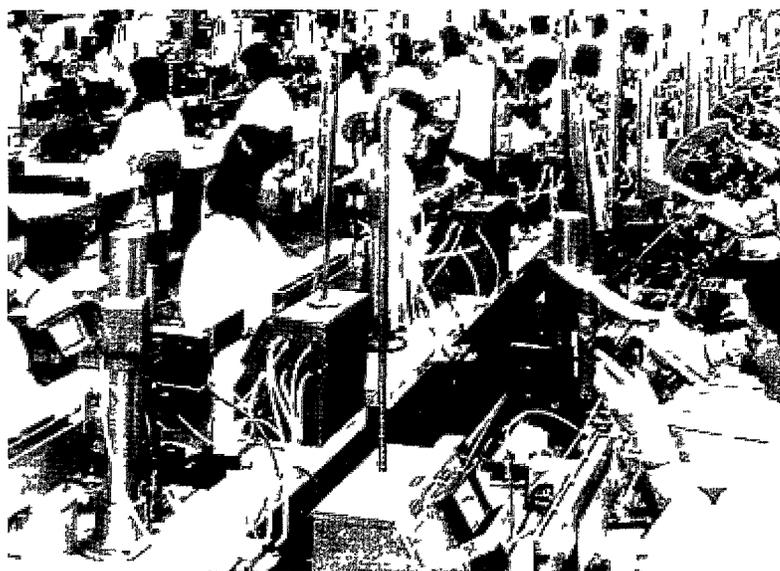
For many women, work outside the home was not greeted with enthusiasm. They felt that their families benefited by their not working, and that they could take better care of the children if they did not work. Other women preferred to have jobs that did not require them to leave home. This made it easier for them to manage the household — which was mostly women's responsibility, irrespective of whether or not they worked outside the home.

## REPUBLIC OF KOREA THE FERTILITY REVOLUTION

South Korea's decline in fertility has been both rapid and widespread. In 1962, the government announced sweeping reforms to stimulate economic development, including the establishment of a national family planning policy designed to curb population growth, which was seen as an obstacle to prosperity. In the decades that followed, South Korea experienced a dramatic increase in the use of family planning and a precipitous decline in total fertility, from 6.0 in 1962 to 1.6 in 1990. During this period, which has been called the "fertility revolution" by some, rapid economic

development lifted the per capita Gross National Product from U.S. \$87 in 1962 to \$8,483 in 1994.

South Korea's two child norm and the availability of contraception have shortened the period women must devote to intensive child care; most women complete childbearing by age 30. While this reduced time in childbearing gives women increased time outside the domestic sphere, Korean women remain less educated than men, and women's participation in the work force has increased only modestly, from 39 percent in 1970 to 48 percent in 1995, with nearly all of the participation in urban areas.



INSTITUTE FOR SOCIAL DEVELOPMENT AND POLICY RESEARCH  
SEOUL NATIONAL UNIVERSITY

*Availability of family planning in South Korea has made it possible for many women to join the work force. However, these non-traditional roles have created stress for younger women.*

South Korea has a strong patriarchal family tradition, based on Confucianism. Women and men have well-defined, separate and distinct roles. Discrimination in employment on the basis of sex is now illegal, and women have the same property rights as men. However, women have made few inroads into formal political structures, where their level of participation is among the lowest in the world. In 1996, women accounted for 3 percent of total Parliament members. In administrative government positions, women comprised 24 percent of government office holders, but only 1.5 percent of top positions.

In South Korea, the WSP supported a pilot project, using private funds from FHI and a grant from the Institute for Social Development and Policy Research, Seoul National University.<sup>64</sup> The goals of this research were to examine the impact of family planning on 1) women's status and participation in the work force 2) women's participation in political activity 3) domestic roles and relationships in the family, and 4) women's self identity.

Because contraceptive use is pervasive researchers did not compare users with non users as was the case in other WSP countries. Instead, the studies compared women's family planning experiences over time by looking at annual statistical data and by comparing older women to younger women. Secondary analysis of annual national economic and social data took place, as well as focus group discussions with older and younger women. Research was conducted by the Korea Institute for Health and Social Affairs, the Korean Women's Development Institute, Ewha University, Korea University, Seoul National University, and Konkuk University.

During the course of this pilot project, South Korea underwent a presidential election and the turmoil and stress of a major economic crisis. Consequently, the country's socioeconomic and political climate became a critical external factor in this study. One focus group discussion was conducted after the crisis to learn if and how women's views had changed.

### **Women's Participation in the Work Force**

This subproject analyzed national statistical data as well as the 1991 National Fertility and Family Health Survey. This secondary analysis focused on two subgroups of urban women from the 1991 national survey: 1,093 women ages 25 to 29 and 644 women ages 45 to 49. Researchers noted considerable differences between the two age groups with respect to childbearing patterns, time spent in childbearing and childrearing, and work force participation.

The typical pattern among younger women was to marry at age 23, temporarily leave the work force to begin childbearing, then return to the

### **FINDINGS FOR**

■ **There are clear generational differences in women's perceptions of their roles and duties in the home, at work and in the community, and in their preferences for sons. There are also generational differences in women's definitions and levels of self esteem. Older women, who define themselves in terms of their successful fulfillment of traditional domestic roles, have higher self esteem and more autonomy than younger women, who experience conflict between their domestic roles and their work outside the home.**

■ **Because of women's increased participation in the work force, some men have become more involved in childrearing and domestic chores. However, this can be a source of conflict between husband and wife.**

■ **The economic crisis has changed younger women's perceptions. Originally, younger women said they had time only for childrearing and work. They expressed little interest in political activities and many did not plan to vote in the upcoming election. Following the economic turmoil of the past year, younger women said they are more interested in the political domain and realize that this affects their domestic and work lives.**

work force once childbearing and childrearing were completed. Younger women wanted an average of 1.9 children, 25 percent expressed a preference for sons. Among those who had completed childbearing, women reported their last birth occurred 34 months after their first.

By comparison, older women married at 22, wanted 2.3 children but averaged 3.05, and had their last child 90 months after their first. Fifty-three percent of the older women expressed a preference for sons. Older women averaged 26.5 years of age at the time of their first job while younger women started working at age 20.6.

But in spite of greater work opportunities for younger women, only 29 percent of the younger women were currently working compared with 57 percent of older women. More than 67 percent of younger women quit their jobs at or around the time they married, compared with 68 percent of the older women. Eighty-four percent of younger women who worked before their first birth quit jobs around the time of first birth, while 70 percent of older women quit jobs around the time of first birth. Among women working outside the home, 17 percent of the younger group and only 2 percent of the older group had professional, technical or administrative jobs. Women were likely to continue working outside the home after childbearing only if they had professional, technical or administrative jobs.

Researchers categorized women's work life into four groups: 1) those continuously working, 2) those currently working with intermittent work history, 3) those currently not working but who had worked before, and 4) those who never worked. Again, differences emerged between the two age cohorts. Most young women (64 percent) fell into the third category while older women were evenly distributed among the four categories. Younger women who continuously worked were more likely to have office jobs, young women who worked intermittently were more likely to work in sales, service and production labor. Older women, whether they worked continuously or intermittently, were more likely to work in sales and service or labor production.

Among younger women, the continuously working women were the most educated. They got married later, had or planned to have fewer children, rapidly completed their desired family size, and were least likely to have a preference for sons. In contrast, older women who continuously worked were the least educated, had the largest number of children and expressed the most desire for sons.

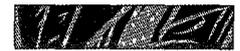
Researchers concluded that the relationship between work history and fertility has changed with increased access to contraceptives but that work and fertility are closely related. Young women's work status appeared to be negatively

related to fertility, with higher work status indicating lower fertility. Among older women, work and fertility patterns were positively related. Researchers have not yet studied the influence of education, which was nearly 12 years for the younger women and only 8.5 for the older women, on women's work and reproductive patterns.

Focus group discussions, which included one group of women in their thirties and another group in their fifties, revealed different work opportunities for women — and different stresses between generations. Older women found their work opportunities limited either by economic opportunity or gender norms that prescribed that they perform all domestic chores. Young women, who had more opportunities to work outside the home, were more likely to share domestic tasks with their husbands, but this was a constant source of friction.

One older woman explained that marriage often forced women to quit their jobs. "It was the bank which didn't allow a woman to continue to work after marriage. That made me quit the job. Today, it seems that the married women could continue working." Another older woman said that the responsibilities of work both inside and outside the home were too much to contend with. "I came out of the house at dawn, went to school and taught many students all day long. Teaching was a hard working job. But even after I returned home, my labor did not finish because the housework, which is always a wife's job, was left undone. It was so hard, I couldn't help quitting the job."

Younger women talked about conflicting demands to be a nurturing mother and a productive worker. "Many of the professional women I know have merged their dual roles successfully. But no one has escaped without personal sacrifice, or struggle or inner conflict." One woman said, "When I left my job, I realized how exhausted I had been. It was an enormous relief to have all this pressure taken off me. However, my first few months at home brought isolation and unanticipated restlessness." Another woman said, "Sometimes I think I am part of an overlooked but particularly confused generation of women."



*" Many of the professional women I know have merged their dual roles successfully. But no one has escaped without personal sacrifice, or inner struggle or conflict "*

South Korean woman

### **Women's Participation in Political Activity**

This subproject explored whether higher education and lower fertility have enabled women to increase their participation in formal and informal political activities. Six focus group discussions were held with high to middle income educated women, grouped by age, to examine gender relations. (Future research will examine the attitudes of low income women.) Again, generational differences emerged. Older women tended to be fatalistic and accepting, while those of the younger generation were more critical of existing gender relations.

For example, an older woman explained that a woman's primary responsibility was to her family. "I don't think men want intelligent women or career women," said one older woman. "Why on earth do they like them? What my children and husband want from me is to satisfy their basic needs on time. Feed them well, have them feel comfortable at home. I think that the intelligence of mothers doesn't do much for children."

But a younger woman said that women can perform multiple roles in society. "People have different kinds of talents and ability. Every woman doesn't need to be good at housekeeping. Women as humans have a limited amount of time and energy. It is not right to ask women to do every thing perfectly. It is not fair either that working married women reduce sleeping time to do household chores after work."

Younger women felt that as working women, they were entitled to receive help with household responsibilities, and they expressed a strong desire to participate in activities in the public domain. However, they spent most of their time fulfilling their home responsibilities. Their desires to work caused distress and frustration, and they noted that it was difficult to maintain a career after exiting and reentering the work force. (This analysis was only partial, since participants were from the middle and upper classes. Future work will compare the attitudes of lower class women to these focus group participants.)

Six additional focus group discussions were held to examine women's perceptions about political activity. Older educated women, while

holding traditional views on the importance of women's roles in the family, expressed dissatisfaction with politics and politicians (this was prior to the 1997 presidential elections). They also expressed more interest and had more information about political events related to the presidential election than the younger women. Older women were unhappy about the cultural changes that they attributed to Western influences and the mass media. Freed from the responsibilities of childrearing, older women were interested in and participated in social activities, such as fundraising for cultural development.

Younger women said their primary interests were their families and work. If they had any time for leisure, they were busy with friends and relatives. They expressed little interest in politics, and many did not plan to vote in the upcoming election. One woman commented that women in politics "should be smart, but I, as a woman, have a negative feeling if a woman is too smart." Like their older peers, younger women performed the household chores, managed the education of children and allocated the family budget. However, younger women said they communicated more with their husbands, who were also likely to be involved in household chores and children's education. Yet this blurring of gender roles often resulted in conflict with their husbands and in laws and led to women's self doubt.

Younger women were reinterviewed three months after the first focus group discussion, following the election and during the economic crisis, they were shocked by cost increases for household items such as sugar, flour and coffee, and expressed a growing interest in politics and politicians. "[It is] not like before," one woman said. "I [have] watched TV news and political campaigns for the first time." While most were politically conservative, they were hopeful that the new government would solve the country's current economic problems.

### **Women's Domestic Roles and Family Relationships**

This subproject looked at the impact of the sex ratio of newborns on family gender roles by economic class. Although contraception is available

and widely used, the rate of induced abortions in South Korea has remained constant during the fertility revolution — 48 percent in 1979 and 49 percent in 1993. Researchers attribute this to the use of sex selective abortion in favor of male fetuses.

Focus group discussions were held with two groups of middle income women and two groups of low income women. Both groups expressed a preference for sons, although it was less strong for younger women. Sons were seen as necessary to preserve the patriarchal lineage, to protect women from their mothers in law, and to provide for families in their old age. Younger women whose firstborn was a son did not plan to have more children, due to the economic crisis. Gender role definitions were strong, with few differences between ages or economic groups. However, because younger women now devote much less time to childbearing and childrearing, actual practices are changing, with women and men sharing household chores. Decision making remains a male domain.

Family economic resources were largely devoted to children and their education, but there were differences between the two economic classes in the amount of resources available for this purpose. Thus, while social class did not affect gender roles or sex preference, it did affect women's ability to fulfill what most consider to be their major role — that of mother.

### Women's Self esteem and Self Concept

To examine the effects of social and cultural change on women's identity and self esteem, researchers collected data through two focus group discussions in Seoul. The first focus group discussion was designed to explore women's concepts of self and self esteem. Focus group discussion participants defined self esteem as feeling confident and competent. They defined the

self on two levels: 1) the self as determined by the individual and by relationships with others, and 2) self as a reflection of power.

Three focus group discussions were held: one with older women who had primarily worked inside the home, one with younger women who worked part time, and one with older women who worked outside the home full-time. Women were asked about their roles as wives, mothers and workers.

The women studied, regardless of age or employment status, had a strong family orientation and based their concept of self on their relationship with others, researchers found. The conventional ideals of the family and the gender division of labor dominated the lives of the older women to the extent that they sacrificed their individual selves for the sake of children, husband,

and in laws. Half the younger women in the sample also gave up their full time jobs when they married in order to fulfill their family duties.

In spite of their focus on others, study participants did possess a concept of the autonomous self. Both older and younger women reported some degree of independent self concept, but there was a generational difference in perspectives of self and self esteem.

Older women based their sense of self on fulfillment of the traditional expectations of women's roles within family — *hyunmo-yangcho* (wise mother, obedient wife). Women in this group believed their most important role as wife is *naejo* — literally, inner assistance taking care of all family matters. "I chose to be with my children, despite my mother's advice that women also should have a job with an independent income like men do," said one older woman, whose mother worked as a trader. In addition, this group's generally high self esteem was attributed to the power that they were able to secure during marriage —



*" I came out of the house at dawn, went to school and taught many students all day long. Teaching was a hard-working job. But even after I returned home, my labor did not finish because the house work, which is always a wife's job, was left undone. It was so hard, I couldn't help quitting the job "*

South Korean woman

power they achieved from fulfilling their domestic roles and recognition from their husbands and children for jobs well done

Self esteem among the younger women was generally lower, due to uncertainty about women's roles, differences between women's views and those of their husbands and communities at large, and women's efforts to secure tangible resources "Korean men have not changed as much as women have," said one young working woman "I think that I am a good wife, but not enough to meet his expectations " Women who worked part time felt that women who worked full time had an advantage over them "Working women may find it hard to combine two jobs now, but they have a hope to become independent persons But my future is uncertain Should I have a job or not?"

Employment can have both positive and negative effects on women's empowerment, researchers found Though an independent income is an asset, employment prevents women from giving the expected time to domestic responsibilities These conflicting roles can mean lower self esteem for young working women

Another focus group discussion, conducted among women ages 20 to 59, explored the effects of family, school, and mass media on gender norms, gender roles with regard to income generation, household work, and the exercise of authority within the household, and gender identity Researchers compared women according to age (20 to 39 and 40 to 59) and concluded that

- Younger parents are more flexible about gender norms and more likely to combine warmth with authority and control in parenting than were older couples
- Teachers' attitudes and behaviors toward gender were traditional, teachers encouraged female students to be compliant, dependent, passive, and quiet
- While school texts and curricula were traditional, younger women recognized stereotypes while older women accepted stereotypes and did not challenge them
- Traditional gender norms were reinforced by the mass media Younger men were portrayed

as strong able and dominant — as leaders and workers Younger women were portrayed as kind, beautiful and helpful The roles changed with age, however Older men were portrayed as weak, while older women were portrayed as strong

- Younger women played a larger role in income generation Working younger women had more help with child care from husbands and other relatives Nonetheless, child care remained the woman's responsibility
- While a few of the older women said that they made the major decisions in the family, all of the younger women reported that their husbands had final authority In general, the older women had more authority, which emanated from the fulfillment of the traditional gender roles of mother and household manager

#### **MALAYSIA CONTRACEPTION, MARRIAGE AND JOBS**

Secondary analyses performed by Kritz et al at Cornell University explored the impact of family planning on marital disruption and women's labor force participation in Malaysia, a country where family planning has been available for the past three decades<sup>65</sup> Researchers used event history techniques to untangle the complex relationships between the use of contraception and subsequent behavioral outcomes in women's lives, including disruption of first marriage, entry into the labor market following first marriage and exit from an occupation after first marriage They also looked at ethnicity and its impact on contraceptive use

Secondary analyses were conducted on data for two samples of women in the Malaysia Family Life Survey a panel of women interviewed in 1976, then re interviewed in 1988 In addition, data from a new sample of women from the Family Life Survey were included Researchers compared selected life experiences of users and non users of contraception and developed models to determine the impact of the use of contraception on marital disruption

They found that contraceptive users were significantly less likely to experience marital disruption This was true for women who used

*" Frankly, sometimes I think I am part of an overlooked but particularly confused generation of women "*

Young South Korean woman

contraception in the 1970s as well as the new sample interviewed in the 1990s. Those effects were stronger for women who used contraception early in marriage, had fewer births and did not work before or after marriage. Effectiveness of method (modern versus traditional) proved less important than the fact that a method was used. This suggests that the negative link between contraceptive use and marital disruption results from a mechanism other than level of control of fertility.

Contraceptive use did not affect either entrance in or exit from the work force. Researchers believe this may relate to the fact that women's jobs in Malaysia at this time were compatible with childrearing.

### **PHILIPPINES FAMILY PLANNING, WOMEN AT WORK, WOMEN AT HOME**

The Philippines provided a geographically and ethnically diverse setting for this WSP supported research. With a population of more than 75 million, the Philippines includes some 7,000 islands, whose residents speak 80 languages. More than 90 percent of the country's residents live on 11 of these islands, with nearly eight million people living in Manila, the nation's capital. Fifty-five percent of Filipinos live in rural communities, but migration to urban areas is increasing.

In spite of the country's cultural diversity, many residents share a common tie — religion. More than 80 percent of the country's residents are Catholic. The church, a dominant force in the nation's political system, often finds itself in opposition to the country's active network of grassroots women's organizations as well as the national family planning program. Advocacy groups promote women's rights, including reproductive rights, while the Church discourages the use of modern contraceptive methods believing they are antithetical to religious teachings.

Nonetheless, 40 percent of Filipinos report using contraception, with one in four users relying on modern methods and one in eight relying on traditional methods. Of those who start using a family planning method, one in three discontinues during the first year, the majority citing concerns about side effects as the reason, according to the National Demographic Survey (NDS).

Unmet need for family planning remains high, with nearly two thirds of married women saying they do not want additional children.

Nationwide campaigns to reduce maternal mortality have yielded positive results in the Philippines. From 1940 to 1990, there was a decline in maternal mortality ratios, from 6.3 to 0.8 deaths per 1,000 live births. Yet five to six women die daily from complications related to pregnancy and childbirth, and many women's groups have said women's health could be improved further if services were expanded beyond maternal and child health programs.

When the WSP began research in the Philippines, it built upon previous work done by the University of North Carolina's Carolina Population Center (CPC), specifically the Cebu Longitudinal Health and Nutrition Survey (CLHNS). The WSP supported secondary analyses of data from the original survey, administered in 1983-86, and a 1991-92 follow up study. In addition, the WSP, initially using money from USAID's Women in Development Office and later USAID Office of Population core funds, supported a follow up study to the Cebu research. This study added a third set of individual, household and community data to the existing data sets. A sub sample of 500 younger women was added to the original sample. This survey provided a comprehensive view, over more than a decade, of women's health and nutritional status, work and income histories, contraceptive use and childbearing experience.

In addition to the research in Cebu, the WSP supported two primary data collection projects, one in Western Visayas to explore the economic and psychosocial influences of family planning on women's lives and another in the southern Philippines to examine the socioeconomic consequences of family planning use. When research began, the impact of contraceptive use on women's work and the impact of work on women's quality of life were central concerns. However, during the process of setting the research agenda, domestic violence was identified by women's health advocates and researchers as a critical issue. Consequently, the Cebu follow up and studies in Western Visayas and the southern Philippines included this topic.

## Cebu Longitudinal Study Secondary Analyses

Researchers from three institutions — the Carolina Population Center at the University of North Carolina Chapel Hill, the University of San Carlos in Cebu, the Philippines, and FHI — conducted secondary analyses of data from the CLHNS. Their

### FINDINGS AND IMPLICATIONS FOR

■ Family planning should be promoted as a means for women to achieve adequate birth spacing, which allows women time to recuperate between pregnancies and lactation. Concern about side effects is a common reason for not accepting or for discontinuing a method. Services and information, education and communication campaigns should provide counseling and clear information regarding methods and their benefits and risks, plus information on how to cope with side effects.

■ Because the number of women in the work force is increasing, employers should consider offering family planning and reproductive health information and services at the work site.

■ Since poverty and rural residence are associated with high prevalence of domestic violence, development initiatives in rural and depressed areas need to increase awareness of violence and increase resources for battered women.

■ Workers at family planning and reproductive health clinics, especially in rural areas, should provide assistance and referrals for women who suffer from domestic violence. Workers should receive training in counseling for victims. Midwives and traditional healers could also be trained to provide assistance and referrals for battered women. Churches, religious organizations, and universities could be encouraged to contribute toward or provide resources, safe haven, and legal services for battered women.

■ Training on gender issues and women's needs should be provided for health workers in local government units and among the barangays. Program managers, policy makers and women's advocates should work collaboratively to develop reproductive health services that are client-centered, rather than provider driven.

■ Health clinics should provide a range of services at times convenient for women, to accommodate women's multiple work burdens inside and outside the home.

goal was to explore the relationships between contraceptive use and women's work. The original CLHNS recruited 3,327 pregnant women from 33 *barangays* (political units) in metropolitan Cebu, who subsequently had a birth or pregnancy termination in a one year period beginning in 1983. The 1991-92 follow up survey included 2,395 of the women in the original survey, and the WSP secondary analysis focused on these women.

The goals of the secondary analyses were to 1) explore the impact of family size and pace of childbearing on women's work patterns in terms of type of work, progression of jobs, income, and compatibility of work with child care, 2) determine the most common patterns of reproductive events in women's lives, and 3) explore the impact of family size and pace of childbearing on objective indicators of quality of life including quality of housing, value of household assets, presence of conveniences and labor saving devices, mothers' nutritional status, children's nutrition, and children's physical and mental development.

Researchers found that high fertility women (those with six or more pregnancies) were, on average, five years older than low fertility women and had two years less education. High fertility women came from households with lower weekly incomes (1,205 pesos for high fertility women versus 1,399 pesos for low fertility women) even though there were more income earners per household (6.6 versus 4.8). While approximately the same proportion of high fertility as low fertility women worked for pay (67 percent versus 71 percent), mean weekly income was lower among the high fertility group (246 pesos versus 308 pesos). High fertility women were more likely to live in rural areas (30 percent versus 22 percent) and were less likely to have electricity in their homes. High fertility women also had poorer diets, although iron intake was comparable for the two groups.

Age at first marriage and first pregnancy was significantly lower for high fertility women. The time span between first and most recent pregnancies among high fertility women was double that of low fertility women (14.5 years versus 7.1 years) and birth intervals were shorter (25.6 months versus 31.8 months). High fertility women experienced

a greater percent of fetal losses (9 percent of total pregnancies) compared to low fertility women (6 percent) Forty eight percent of high fertility women reported at least one pregnancy loss, compared to 22 percent of low fertility women

Not surprisingly, current use of family planning was more common among low-fertility women (57.7 percent versus 47.3 percent for high fertility women), as was modern family planning method use (30.4 percent versus 22.1 percent) High fertility women reported greater reliance on traditional methods There was no significant difference in breastfeeding duration between the groups (only those who initiated breastfeeding were analyzed), but high fertility women breastfed a larger number of their children for longer than 12 months and were more likely to be currently breastfeeding (28 percent versus 14 percent of low fertility women) <sup>66</sup>

The WSP secondary analyses in Cebu also looked at women's work patterns <sup>6</sup> At baseline, 47 percent of the survey participants were working for pay, in 1991, the figure had increased to 74 percent Workers were more likely than non workers to have more children, to be from households with lower incomes, to have worked prior to marriage, and to have a higher education Of those working for pay in 1983, 42 percent were self employed (most in small stores or as street vendors), 31 percent were paid set wages (salary based on hours or days of work), 21 percent did piece work (mostly handicrafts) and 7 percent worked in family businesses By 1991, the percentage of women doing piece work had declined to 15 percent, while the percentage of women who were self employed rose slightly to 44 percent The likelihood that a woman was working in both 1983 and 1991 was higher if she had several children in 1983 and was lower if she had a child under two years of age in 1991

Among women who worked at both points in time mean weekly income increased about 47 pesos from 1983 to 1991 Data suggest that earn

ings per unit of work time tend to decline with increased childbearing, possibly because child bearing women shift to lower paying jobs that are more compatible with reproductive roles The mean change in income for women with no subsequent surviving child in the eight year study interval was 2.3 times higher than that of women with at least one additional child The change in income in part reflects an increase in hours worked, from 42 hours in 1983 to 46 in 1991 Piece workers had the lowest gains in wages, while wage workers had the highest (average total increases of 19 and 63 pesos per week, respectively)

Income gains were not affected by the total number of children a woman had but rather by the number of additional children born during the study interval Multivariate analysis showed that the negative impact of children on earnings appeared to be temporary, since children age eight or younger affected their mothers' work hours and wage increases, but older children did not

Furthermore, the manner in which earnings increased varied by sector of employment Women who remained in the wage sector increased their earnings through improvements in hourly wages, while self employed women increased earnings by increasing hours worked

Gains in women's income were made partly through increases in hours worked, which may exacerbate the conflict between women's reproductive and productive roles While women's work hours increased to an average of 46 hours per week in 1991, women reported, on average, spending more than 23 hours per week doing household chores Consequently, women's work may not enhance the quality of women's lives

In the secondary analyses, women's quality of life was measured not by self report, but rather by summary measures of the quality of housing, the value of selected household assets, the presence of conveniences/labor saving devices, mothers' nutritional status and measure of child nutrition, and child physical and mental developmental status <sup>68</sup>



*" My husband and I never used any family planning method because my husband refused me permission to do so "*

**Woman in Cebu  
the Philippines**

Using multivariate analyses, researchers found that for all measures of quality of life except maternal nutrition, a subsequent pregnancy during the eight year study interval had a significant negative effect on quality of life indicators. Each additional pregnancy significantly decreased the quality of life score. Women who had no further pregnancies entered the study with “better” quality of life and this continued throughout the study interval. Women who had undergone tubal ligation tended to have lower quality of life scores than did women who discontinued childbearing for other reasons. Researchers concluded that sterilized women in this particular setting may have chosen tubal ligation for health reasons.

### Cebu Longitudinal Follow-up Study and In depth Interviews

In addition to the secondary analysis in Cebu, the WSP supported a follow up study in 1994-95. The new study focused on women’s work and income histories, health and nutritional status, education, and decision making within the home. The study sample included more than 2,000 urban and rural women from the original CLHNS who are still living in the metropolitan Cebu area. In addition, a new sample of 500 women, ages 15 to 25, was added. Following the survey, three in depth ethnographic interviews (totaling five to seven hours) were conducted with a subset of 60 women to provide detailed information on women’s decision making processes.

This subproject had two goals: 1) to examine the relationships between family planning and various aspects of women’s lives, specifically, decision making, autonomy, and social status, and 2) to update data collected during the original CLHNS and the first follow up survey, allowing better understanding of the relationships between women’s work and family planning use.

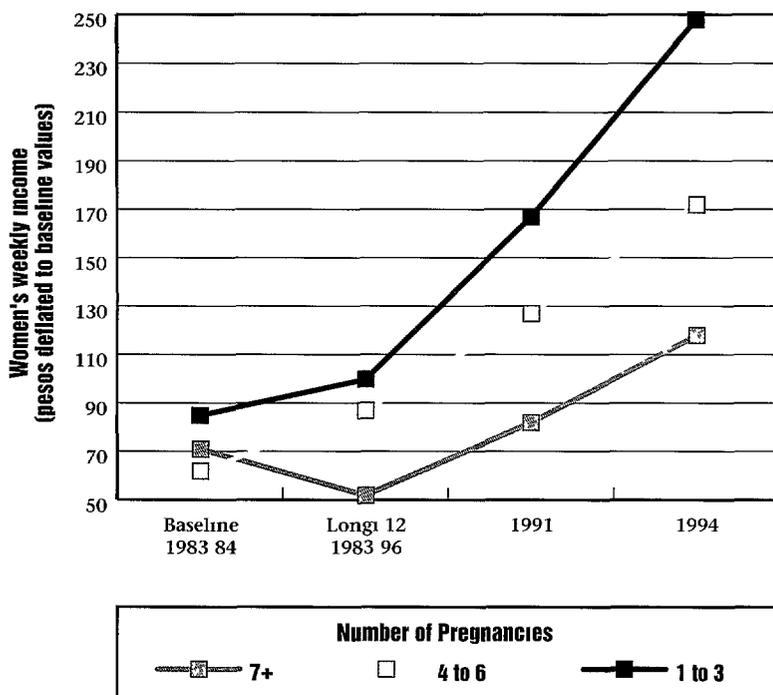
Researchers found that the use of modern methods of contraception increased birth spacing by an average of 13 months, while natural methods increased spacing by five to seven months. Family planning use did not, however, decrease women’s overall number of children. Researchers also found that women were most likely to work when their husbands’ incomes were insufficient, while having young children decreased the likelihood of women working. Women who worked consistently tended to earn more if they had fewer children. (See Table 7, this page.)

Researchers developed a series of questions designed to explore women’s autonomy with regard to decision making in the home. Questions included, “Do you consult with someone when you have to decide on a particular matter?” If yes, “Who do you consult?” and “Whose will prevails on this matter?” If the woman’s will did not prevail, she was asked, “What do you do when you are against such a decision?”

Few women reported that they have no say in minor decisions related to children or purchase of clothing or gift giving. In contrast, a larger



**TABLE 7 Philippines Income Progression among Women Consistently Working for Pay by Total Number of Pregnancies**



Sources: WSP, Carolina Population Center, and Office of Population Studies, University of San Carlos.

percentage of women said they had no say in decisions about major issues, such as the purchase of appliances, land purchase working outside the home, or hiring household help. Joint decision making was typical in the case of buying land and schooling children. In decisions about whether to use family planning, only 12 percent of women said they made autonomous decisions. Among women who consulted their husbands, 25 percent said that in cases of conflict, the woman's decision prevailed, while 7 percent said the husband's will prevailed.

These results led the researchers to question the value of autonomy in Filipino culture and to delve more deeply into question formulation in this area. Just what does it mean to "consult?" Is it culturally appropriate to say that a decision is made jointly?

In in-depth interviews, women told researchers that family planning decision making was a dynamic process that changes over time. (Women's responses about family planning decision making from the quantitative survey tended to reflect the most recent decision making experience.) Cebuano women viewed their marriages as pivotal to their lives. Family planning use was secondary to good communication and negotiation in their relationship.

For couples who did choose a method of contraception, safety and efficacy, including contraceptive side effects, were important considerations. One study participant detailed her difficult search for a satisfactory contraceptive. "Because of the emotional stress that I experienced after the death of four of my newly born babies, my husband suggested the use of some family planning method to avoid further stressful experiences. So I decided first to use pills, from which I later switched to IUDs and still later to Depo Provera. However, my menstrual flow began to become scanty, my husband asked me to discontinue with these modern methods and began to practice withdrawal."

Researchers evaluated and compared qualitative and quantitative results and concluded that women's perceptions of important life events were consistent over time — that women's descriptions of key events in their lives did not vary, although they might emphasize different aspects of the experience on different occasions.



BARBARA BARNETT, FHI

*While women's work hours increased to an average of 46 hours per week in 1991, women reported, on average, spending more than 23 hours per week doing household chores. Small children increased women's domestic workload in the Philippines.*

In this study, researchers also examined social status by observing the conditions in women's homes. Women were more likely to have higher status if they had a maid, were older, had a higher level of education, higher income, fewer pregnancies, and worked for pay. Researchers found that autonomy in decision making was not related to either social status or economic status.

Women were questioned about domestic violence, identified as an important issue by women in focus group discussions. Among ever-married study participants, 13.7 percent said their spouse had physically hurt them when he got angry. Of these, the majority (55.6 percent) said this happened rarely, 27 percent said it occurred two to four times per year, and 17.4 percent said it happened more than four times a year. Women who were physically hurt by their partners reported more pregnancies (6.6 versus 5.9). Abused women said their spouse was less likely to turn over all or some of his earnings, and these women were contributing a higher percentage to the total household income (31.7 percent) compared with women who did not report abuse (25.3 percent).

### **Economic and Psychosocial Influence of Family Planning on the Lives of Women in Western Visayas**

This study was carried out in Iloilo, from 1995-97, by the Social Science Research Institute of the Central Philippines University, with collaboration from the Women's Resource Center and the Family Planning Organization of the Philippines.<sup>70</sup> The study included interviews with 1,100 married women of reproductive age and 50 key informants. In addition, nine pre-survey and 27 post-survey focus group discussions were held with women, men, community leaders, women's advocates, and family planning providers.

Project goals were to describe the relationship between family planning use and 1) economic characteristics of women, such as involvement in paid work, type of work, and work status between pregnancies, 2) social characteristics of women, such as education and training, and participation in social organizations and community activities, and 3) psychological characteristics of women, such as satisfaction with life, perceived self-esteem, and decision making autonomy.

More than half (52.6 percent) of the women interviewed said they currently used or previously used a modern contraceptive method, and almost 90 percent of the users were satisfied with their present method. Women reported an average of 3.8 pregnancies and 3.5 live births. Women who were older, lived in rural areas, and had less education were likely to have more children. Work status was not associated with number of children.

Family planning use was, however, associated with paid work, even when age, residence, educational status, number of children, religion, and household size were controlled. In fact, women who used family planning and had larger families were more likely to be working than women with fewer children. Work tended to be

traditional, seasonal, and low paying, and income from women's work was used for household expenses.

Contraceptive use was also associated with vocational training, higher levels of education, and professional advancement. Contraceptive users were more likely to be involved in community activities, such as the Parent Teacher Associations, beautification projects, and religious and health activities. Both women and men said having time free from childrearing allowed women to participate in community activities. Women said community projects increased their satisfaction and sense of self-worth by expanding their realm of activity beyond the household. However, women said they had little time to participate in political organizations.

Contraceptive users were somewhat more satisfied with their lives than non-users. Similarly, users were more likely to share decision making with their husbands about their work outside the home, travel outside the community, contraceptive use, and childbearing.

Domestic violence was a major concern for many study participants. More than one third said they had been victims of physical or psychological abuse by their spouse. Contraceptive use did not reduce their risks, nor did work status. Women attributed domestic violence to men's alcohol use, jealousy, financial problems, or other family problems. Most abused women turned to friends and relatives for help, if they sought help at all. (Interviewers in this study were trained to provide referrals for women who reported domestic violence. However, they found that very few women sought assistance.)

In focus group discussions, many women said they wanted to use family planning but did not because of fear of side effects. Men also were concerned about contraceptive side effects. Some expressed fears that vasectomy would adversely affect their health and physical strength.



*“Initially, when my husband did not have a steady job, he agreed with me on the use of calendar rhythm. My husband was even the one who plotted my menstrual cycle on his calendar, which he always carried in his pocket.”*

**Woman in Cebu  
the Philippines**

## Social and Economic Consequences of Family Planning Use in the Southern Philippines

This study, conducted from 1995-98, examined contraceptive use and women's psychosocial well-being and their time allocations for work and leisure.<sup>1</sup> Conducted by the Research Institute for Mindanao Culture (RIMCU) at Xavier University in Cagayan de Oro City, Northern Mindanao, researchers used quantitative and qualitative methods, specifically survey and focus group discussions, to study the perspectives of some 1,650 urban and rural women in Mindanao. RIMCU collaborated with the Women's Forum of Region 10, a women's advocacy group that focuses on socioeconomic and domestic violence issues for women and children.

The subproject's goals were to 1) describe how women assess their strategic reproductive needs, 2) describe women's perceptions of how contraceptive use satisfies their reproductive needs, 3) describe how family planning use is associated with changes in women's employment, domestic work, family roles and interpersonal relations, reproductive health, and community participation, and 4) examine the prevalence of domestic violence.

A sample of 650 ever-married rural women, ages 15 to 49, who were initially surveyed in 1994 for a maternal and child health study funded by the United Nations Children's Fund (UNICEF), participated in this survey. This group of women represented high- and low-income neighborhoods and tribal communities in Bukidnon province. A second sample of 1,000 urban women, ages 15 to 49, was selected from communities in Cagayan de Oro. Focus group discussions were held with urban and rural participants and included contraceptive users, non-users, and their husbands.

Researchers found that ever-use of family planning was 48 percent, while current use was 27 percent. Family planning use rates among rural women were lowest for women living in tribal



*" I want to have seven children by the time I will be 35 years old. It is good to have many children because they are useful around the house "*

**Woman in Cebu the Philippines**

villages (19 percent) and highest for non-depressed rural areas (34 percent). The IUD was the most commonly used method (46 percent), followed by oral contraceptives (30 percent). Among women who ever used family planning, 31 percent experienced a pregnancy while using family planning, and 46 percent experienced at least one unwanted pregnancy.

The majority of women said they had the autonomy to choose a family planning method, and, in cases of conflict, they had the final say. Women tended to make minor everyday decisions about the house-

hold economy, but major decisions involving large expenditures were the husband's domain.

Domestic violence was prevalent — one in four women reported physical abuse, while two out of five reported verbal abuse, such as name-calling. The perpetrator was most likely to be the woman's husband. Among those who experienced physical abuse, 19 percent said that the abuse was repeated frequently. Physical abuse occurred when the husband was drunk or during quarrels and disagreements, women said. They also attributed violent outbursts to husbands' jealousy, gambling, extramarital affairs, or participation in *barkada* (groups of friends who gather for drinking, gambling and other activities). Women said they were seen as the cause of violence if they refused to have sex, were negligent in caring for the children, left home without their husband's knowledge, or had difficulty adjusting to their husband's behavior.

Women were more likely to be abused if they lived in an urban area if their husbands performed household tasks (specifically cleaning, washing and marketing), if women worked outside the home, if women made decisions on child discipline, and if the family had few household possessions. Women who used contraception and those who reported unwanted pregnancies also had a higher incidence of domestic violence. (See Figure 2, page 76.)

Another important finding from this study was that women spent a significant portion of their day on domestic tasks. The average number of hours in daily home production was 6.0 for urban women and 6.5 for rural women. Caring for children and preparing food were the activities that took the largest share of women's time. Moreover, it appeared that domestic work

constituted a significant portion of the daily schedule of women who were engaged in income generating activities. For instance, women who worked in the formal and informal sectors spent an average of 3.2 hours and 5.2 hours per day, respectively, on domestic work. When hours in domestic and income earning work were combined, women in the informal and formal sectors worked 8.3 and 10.2 hours, respectively, compared with a total of 6.9 hours for women not working for pay.

Women's hours in domestic work increased as the number of children increased, multivariate analysis showed. Having children under five years of age significantly increased the number of hours women spent in household work. "I am always busy when the children are up," said one woman. "I am only free from work when the children are asleep," said another. But having more children also increased women's workload outside the home.

Pre survey focus group discussions among urban, rural and Muslim women found the three groups of women held similar views about work. Money was the main reason women sought employment, and women said they needed to work to augment the family income, even though they knew a larger family size meant a greater work burden at home.

Research in the Philippines provided a rich source of data on women's experiences with family planning. Women have benefited from contraceptive use, in terms of improvements in their health and increased opportunities to pursue income generating activities as the time spent in childbearing declines. Yet women who now have the freedom to work outside the home are not always free from domestic chores, and women's total work burden has increased. The Philippine studies dramatically illustrate that family planning has not enhanced gender equity.



**FIGURE 2 Philippines Domestic Violence in Northern Mindanao**

Correlates of Abuse\* (n=1 660)

**Demographic**

---

Urban area of residence

---

Young age at first marriage

---

Catholic religion

---

Low total household income

**Family Planning and Reproductive Status**

---

Ever use of family planning

---

Long duration of family planning use

---

Experienced unwanted pregnancy

**Household and Gender Roles**

---

Wife earns income

---

Husband controls household income

---

Husband shops for food

---

Husband cooks meals

---

Husband cares for children

Chi square less than .05

## LATIN AMERICA AND THE CARIBBEAN

### BOLIVIA GENDER, SEXUALITY AND REPRODUCTIVE HEALTH

The WSP supported six subprojects in Bolivia, a country where gender norms (including machismo) strongly influence attitudes about sex, family size and couple relationships. Bolivia has one of the highest fertility rates in the Western Hemisphere — 4.8 births per woman. The country also has one of the highest maternal mortality ratios in Latin America — 390 deaths per 100,000 live births. Contraceptive use has increased significantly from 30 percent in 1989 to 45 percent in 1994, but more than half of those who use family planning rely on less effective methods. The unmet need for contraception remains high, particularly in rural areas and among indigenous populations.

In the 1970s, the government promoted a pronatalist policy, and contraceptives were not readily available in public clinics. Today, the government views family planning as an essential component of reproductive health, evident by its establishment in 1990 of the first National Reproductive Health Program. The government also established a Subsecretary of Gender, as part of the Ministry of Human Development, to improve women's status and promote gender equity across all government sectors.

Historically, Bolivia has had a rural economy, with the majority of its residents employed in agriculture or mining. In recent years, however, there has been an increasing trend of migration from rural to urban areas. Indigenous groups, primarily Aymara, Quechua and Guarani, have moved to La Paz, El Alto, Cochabamba and Santa Cruz. Chronic underemployment among Aymara men has led to women's increased participation in the informal labor sector.

Four WSP subprojects have been completed in Bolivia: a study on how family planning affects the psychosocial well-being of women, including sexuality and self-esteem; a study on how male attitudes affect women's contraceptive use and access to reproductive health services; and a study on health services in El Alto; and a case study of two

### FINDINGS AND IMPLICATIONS FOR

- Compared with users of traditional methods or no contraceptives, couples who used modern methods were more likely to report higher levels of satisfaction with their marital and sexual relationships, possibly because fear of unplanned pregnancy was reduced. Policy makers and providers, who often promote the health and economic benefits of contraception, could promote this psychosocial benefit as well.
- For many women, domestic violence is a common occurrence. The causes of male-female abuse are complex — poverty, unemployment, alcohol abuse, and control over sexuality. Some women in Bolivian studies spoke of violence in retaliation for their refusal to have sex. Health providers should be educated about the prevalence of domestic violence and should understand that for many women, violence is the context in which contraceptive use occurs. Providers should consider linking with NGOs and other organizations to develop referral systems for abused women who seek help. Policy-makers should consider mass media campaigns to educate the public about the prevalence of domestic violence and resources for couples. Legislators should reconsider the current law that requires health care providers to report cases of domestic violence since this may actually discourage some women from seeking health services.
- Couples do not always communicate about family size, and men and women often have different perspectives on their ideal number of children. Health programs and NGOs could offer workshops to help couples learn how to improve their communication skills. Mass media campaigns, depicting couples who talk about family size, should be conducted.
- Men must be educated about reproductive health, including contraception options available to them, the benefits of family planning for the couple and the family, and possible side effects for women who use contraceptive methods.
- Because many couples rely on traditional contraceptive methods, such as the rhythm method, sexual and reproductive health programs should offer education on male and female fertility cycles, to improve efficacy of this method.
- Myths and rumors about contraceptive side effects prevail. Sexual and reproductive health programs should consider community education programs about specific methods and individual counseling to help clients anticipate side effects and recognize health problems that are not related to contraception and may require medical attention.
- Providers should receive additional training in communication and counseling skills, to help improve their interaction with clients.

women centered health programs in El Alto and Santa Cruz published in 1996 and available on FHI's web site

Ongoing projects include an effort to develop training materials on gender sensitive guidelines for reproductive health services, conducted with the Centro de Informacion y Desarrollo de la Mujer (CIDEM) In addition, analysis of a follow up to the 1994 DHS survey is near completion, preliminary results are presented in this report

### Psychosocial Impact of Fertility Regulation on Women

In El Alto, researchers conducted in depth interviews to examine relationships between contraceptive use/non use and quality of life, including factors such as couple stability, the quality of relationships, sexuality, women's self esteem and decision-making<sup>3</sup> Three groups of women (approximately 35 members each) were interviewed — those who used the IUD or condom at the time of the study, those who discontinued modern methods for reasons other than desire for pregnancy, and women who knew about modern methods but had never used them A group of 31 men also was interviewed The Proyecto Integral de Salud (PROISA) conducted the study

There were no marked differences among the three groups of women Contraceptive users and non users held similar views about overall quality of life, couple stability, and women's self esteem and decision-making, although there were some differences in their perceptions of sexuality For instance, when compared with women using traditional methods, modern method users had more positive attitudes about sex and discussed their reduced fear of pregnancy Researchers found that fear of pregnancy was widespread among both women and men One rhythm user said, "I don't ever want to go to bed because I am afraid of getting pregnant " For men and women, fear of pregnancy was sufficient reason to avoid sex As one man explained, "We avoid having relations, that's all "

There were striking differences, however, between women and men In general, women were much less comfortable expressing their sexual needs and less likely to enjoy sex For some women, sex was a source of agony, accompanied by violence, coercion and verbal abuse Men reported that women initiated sex more often than women themselves claimed to initiate sex Women described their relationships with their partners as a major problem — something men did not report Women said they resolved problems at home, while men said they were responsible for problem solving Men said they made the decisions at home but women said decisions were made jointly Men also said they helped with daily household chores, but women said men offered little assistance Researchers have not determined whether these discrepancies are true differences whether they reflect "socially acceptable" answers, or whether they reflect a hesitancy to answer intimate questions accurately

Female study participants said their children were central to their lives Children were their main reason for living, and children helped them feel fulfilled and happy The qualities they admired most in themselves were being a good mother, wife and homemaker Compared to women in

other countries, the women in El Alto placed a lower priority on how they looked and more emphasis on how they felt (healthy or not) Women's concern with their bodies primarily was focused on how well they could perform household tasks For example one woman commented that her hands were her favorite part of her body "because they help me work "

Although women and men in this study frequently talked about desired family size, they did not always talk about how to prevent unwanted pregnancies Among IUD users, only half consulted their partners before the insertion procedure — although nearly all discussed IUD removal with their partners In communicating about sex, some women said they were too shy, too timid or too busy to broach the subject with their partners One



*" I don't ever want to go to bed because I am afraid of getting pregnant "*

Woman in El Alto Bolivia

woman said, "He works apart He only comes to sleep We have little time to talk " Another said, "I'm a little shy with him I express what I have to, but with fear, and it embarrasses me " Among male study participants, two-thirds said that family planning was a joint decision with their partners, although less than half the women said it was mutual decision And for some, there was no decision at all "Our children just arrive is all," said one woman "At times, I feel so sad He, too, says, 'What are we going to do? God must want us to have more babies ' So this is how it is "

Other study participants said communication about family planning was essential "We always talk," said one rhythm user "It's got to be that way, mutual agreement, no?" Another said, " They gave me the talks on family planning, then I discussed these with him, and the two of us agreed that I should have [a Copper T IUD] put in " Another woman said, "Yes, I can talk about it I can tell him with total confidence what I like He says to me, 'I'm your husband, you have to tell me how to satisfy you ' "

Among the male study participants, more than half said they supported family planning <sup>4</sup> Men said contraceptive use could improve their quality of life and their economic status One man said, "Yes, [contraceptive use] would be better because by not having so many children, the situation can improve, because one would not have so many expenses " However, some men and women feared contraceptive side effects — both real and rumored 'I'm not in agreement [with contraception]," said one man "Because at times people tell us the truth, and at times a lie, and it makes us doubt the truth Sure, at times I think of using those methods, but later I decide not to "

For some women who feared pregnancy, another fear was also present — the fear their husbands would become angry if they refused sex One third of study participants said either they were not able to articulate their refusal of sex or that their wishes would not be obliged "Yes, I can

tell him, but he doesn't respect what I say," said one woman "Yes, but at times, he insists," said another

For many women, insistence manifested itself as violence One participant said, "He told me we were going to make love, and I didn't want to, and he said, 'Why is it that you never want to? Don't I give you pleasure? I said, 'Don't hit me Why do you want to force me like this?' He kept hitting me " Another woman said, "I tell him I like it during sex so that he won't hit me " Said another, "I don't really like to have sexual relations, but he does, and so when I complain, there are times when he forces me as if he were raping me It makes me feel strange "

Violence was prevalent among women in all three study groups Eighty two of the 96 women interviewed said they had been physically or verbally abused at some time in their relationship, although many said the violence no longer occurred One woman said, "Yes, many times earlier, many times I have been hit, and for that reason I have also had an abortion provoked by him Another pregnancy ended in birth a lot sooner than it was supposed to because he hit me Many times I have been hit by him, but that was before But now with our young children, no, no more " Some women said they had hit their husbands,

claiming they did so in self defense One woman said, "Yes, [I've hit my husband] because he also hits me I have to defend myself, right?"

Of the 31 men who were asked about violence, all said they had either physically or verbally abused their partners Men said verbal abuse was common between men and women, but men were more likely to be physically violent than women "Yes, she insults me all the time," said one man "But it bothers

me, and I react because I don't like that she insults me [I react] with punches, of course "

Ironically, in spite of the numbers of women and men claiming abuse, most women said they got along well with their partners and that their partners respected them



*" He grabs me  
like a rag  
He does whatever  
he wants to He  
treats me badly "*

**Woman in  
El Alto Bolivia**

When asked what was their biggest problem at home, women replied, “men drink too much.” One third of women said they had been forced to have sex with their partners, and alcohol was a factor. One woman said, “When he’s drunk, he forces me to have sex. That’s why I’m scared when he’s drunk. I’m hoping he will just go to sleep.” A man, asked if he had ever forced his partner to have sex, replied, “Well, perhaps once in a while when I am inebriated — but consciously? No.”

### **Impact of Men’s Knowledge, Attitudes and Behavior Regarding Fertility Regulation on Women’s Lives in Cochabamba**

Few studies in Bolivia have explored gender dynamics in contraceptive use and the influences men have on women’s access to family planning methods, services and information.

While a long held belief in Bolivia has been that men did not view family planning favorably, this study, conducted by the NGO, Cooperazione Internazionale (COOPI), found that men are both knowledgeable and supportive of contraception. In fact, men’s knowledge of family planning methods was slightly higher than women’s. However, researchers also found that some couples do not communicate about family size.

COOPI surveyed 630 couples of reproductive age (ages 20 to 49) living in urban Cochabamba, who were married or in a consensual relationship. Prior to development of survey questionnaires, researchers conducted eight focus group discussions to develop measurements for self esteem, self determination, overall relationship with partner, and sexual relationship with partner — issues that were to be examined further by COOPI researchers.

More than 90 percent of study participants said that they approved of family planning, that their partner approved of family planning, that men should take responsibility for family planning by using contraceptive methods, and that men should support their partner’s decision to use contraception. Ninety nine percent of men and 93 percent of women knew of at least one modern contraceptive method. Ninety five percent of those surveyed said they and their partners were satisfied with their current contraceptive, IUDs and

condoms were the most widely used methods. Ten percent of women not using contraceptives were at risk for unplanned pregnancy.

Among those who said they were dissatisfied with their contraceptive, men and women offered different reasons for their points of view. Men who were dissatisfied said contraception interfered with their sexual pleasure, others said they feared their method was ineffective. Among women who were unhappy, some said they feared their method was ineffective, while others said they did not want to use a method because they wanted more children, and still others cited side effects, such as nervousness and weight gain.

About half of those interviewed reported using a modern contraceptive method at some point in their lives, some two thirds reported having used a traditional method, such as rhythm or withdrawal. Two thirds of study participants said they were current users, 41 percent used a modern method while 26 percent used a traditional method. In spite of the prevalence of traditional method use, only 67 percent of women and 53 percent of men using these methods could identify the fertile time during a woman’s menstrual cycle.

As noted previously, couples did not always communicate about family size. Only half the men and women said they talked about the number of children they wanted, and similarly, not all couples discussed contraceptive use. Couple concordance about which method they used ranged from 64 to 87 percent. Concurrence was lowest among users of traditional methods, which are dependent on partner communication.

In addition to questions about male and female attitudes toward family planning, the COOPI study also examined psychosocial factors associated with women’s contraceptive use and non use. Researchers found that women who used modern methods reported greater sexual satisfaction. To measure sexual satisfaction, women were questioned about whether they could tell their partners when they did or did not want to have sex, whether it was acceptable for women to initiate sex, and whether they felt free to tell their partners what they did and did not like sexually. Women



*“ Yes, many times  
earlier, many times  
I have been hit,  
and for that reason  
I have also had  
an abortion  
provoked by him  
Another pregnancy  
ended in birth  
a lot sooner than  
it was supposed  
to because  
he hit me ”*

Woman in  
El Alto Bolivia

who were most satisfied with their sexual relationships were those who used a modern method during the past 30 days, had been married less than five years and had some college education

Women with high self esteem (determined by whether the woman viewed herself as a good mother and partner, good at work, responsible, happy, and smart) were also more likely to report high levels of sexual satisfaction. Contraceptive users were more likely than non users to have higher levels of self determination (measured by whether or not a woman managed her own money or the family's money or whether she could decide what to wear)

This study yielded different findings about male attitudes on family planning, when compared with the previous study on men in El Alto. It is important to note that the studies were conducted in different geographic areas, and that the COOPI study included a larger study population with diverse socioeconomic backgrounds. In addition, the research methods were different, the El Alto study included in depth interviews while the Cochabamba study used a multistage probability sample.

### Access to and Use of Reproductive Health Services in El Alto

The goal of this subproject, funded primarily by the United Nations Population Fund and conducted in collaboration with the NGO, PRO MUJER, was to understand better the use of reproductive health services in the Altiplano region, particularly the needs of migrants living in urban El Alto.<sup>7</sup> Researchers examined access and barriers to reproductive health services and assessed the quality of services provided at private and public health facilities. The WSP staff provided technical assistance, including questionnaire development and training in the use of Ethnograph software for analysis of qualitative data. In addition, the WSP supported a consultant who prepared a paper for a local reproductive health journal, *Opciones, Revista Sobre Salud Sexual y Reproductiva*.

Twenty focus group discussions and 50 in depth interviews were conducted with men and women in five rural communities from which



SARAH JOHNSON/FHI

Women in traditional dress said they felt they were not always treated with respect at family planning clinics in Bolivia

most of El Alto's migrants come. An additional eight focus group discussions and 55 in depth interviews were held in El Alto. Finally, a situation analysis of all reproductive health service delivery sites in El Alto (approximately 75, including 35 pharmacies) was conducted. (See Table 8, page 82.)

Investigators examined three aspects of quality of services: interpersonal relations, availability of contraceptive methods, and acceptability of services from three different perspectives — those of service providers and program directors, clients, and non users. While providers gave themselves high marks for their treatment of clients, clients were less positive. Providers also held a different perspective about time — they perceived waiting times to be less and the duration of a consultation to be longer than clients. Women who wore the *pollera*, the traditional female dress of the Altiplano, were more likely to feel discriminated against in health facilities, researchers found.

Contraceptive supplies were limited, and certain groups of clients were excluded from services. In spite of a national policy to provide reversible contraception at health centers, 15 of 36 institutions had none of these methods in stock. Clinics, especially public facilities, often did not provide



*" We don't talk about it [sex] because we are ashamed "*

Woman in El Alto, Bolivia

**TABLE 8 Bolivia Perceptions of Service Delivery among Providers, Contraceptive Clients and Non-clients**  
(in percent)

	Providers/Types of Service		Clients/Types of Service		Non clients (n=215)
	Public (n=36)	Private (n=49)	Public (n=99)	Private (n=118)	
<b>Physician treatment of clients</b>					
Excellent/Good	83	98	57	75	12
Moderate	17	2	39	24	52
Poor	0	0	4	1	22
No response	0	0	0	0	14
<b>P Value*</b>	<b>01</b>		<b>01</b>		
<b>Explanation provided before physical examination</b>					
Yes	100	98	72	77	—
No	0	2	28	23	—
<b>P Value*</b>	<b>39</b>		<b>40</b>		
<b>All clients treated the same</b>					
Yes	—	—	64	72	17
No	—	—	9	3	48
<b>P Value*</b>	<b>na</b>		<b>18</b>		
<b>Waiting time</b>					
15 30 minutes	53	61	43	46	—
31 59 minutes	28	31	28	33	—
More than 60 minutes	19	8	29	21	—
<b>P Value*</b>	<b>31</b>		<b>38</b>		
<b>Duration of consultation</b>					
1 10 minutes	33	37	57	49	—
11 15 minutes	45	26	26	36	—
More than 15 minutes	22	37	57	49	—
<b>P Value*</b>	<b>18</b>		<b>23</b>		

Chi square statistic

services for adolescents. In general, providers, clients and non users tended to perceive NGOs as better than governmental services.

Increased access to contraceptive methods and training for providers on how to improve their interactions with clients were among researchers' suggestions for improving services in El Alto.

### **Women's Participation in the Work Force Follow up to the 1994 DHS**

This WSP longitudinal study builds upon the 1993-94 DHS representative sample of women in El Alto and La Paz. In 1993-94, researchers interviewed 1,308 women. Of these, 816 or 62 percent were re-interviewed for the WSP study. Fourteen women declined to participate in a second interview, and seven women died during the three year study interval.

This study investigates the relationship between fertility regulation and women's participation in the work force. Study goals were: 1) to determine the independent effects of contraceptive use and use of reproductive health services on work status and work related characteristics in 1997, stratified by women's economic activity status in 1994, 2) to determine how a pregnancy during the study interval affected women's economic activities in terms of current work status, type of work, earnings, hours worked and satisfaction with work, 3) to identify the role that use of contraception and/or reproductive health services played in increasing women's material resources and quality of life, 4) to describe the reasons why women work — whether for economic need or personal advancement and satisfaction, and 5) to identify factors associated with meeting fertility goals stated in 1994.

Preliminary results show that a growing number of women entered the work force during the study interval. Sixty four percent of women worked outside the home in 1997 compared with 58 percent in 1994. In addition, almost all women reported working for pay in 1997, while in 1994 women reported working for other types of remuneration, including working for housing. Factors associated with working in 1997 included having worked in 1994, being older and using contraceptives during the survey interval.

In 1994 in La Paz, 38 percent of all study participants were using a family planning method. The percentage did not change in 1997. In La Paz and El Alto, modern method use rose slightly, but traditional method use decreased significantly in El Alto. Also in El Alto, 33 percent were using a contraceptive method in 1994, while only 24 percent were using a method in 1997.

One third of the study participants in La Paz and 41 percent in El Alto reported partner violence, defined as verbal or physical abuse. About 40 percent of the women interviewed reported chronic abuse. Using logistic regression, a history of partner violence was more likely among women who were working, were not in union, had more children, who had partners with less education, and who had used contraception between surveys.

Researchers believe that as women enter the labor force in increasing numbers, contraception is an enabling factor. The role of contraception in the area of family violence is more ambiguous, but researchers believe that as women remove themselves from unsafe relationships and form new relationships, contraception may be a confounder in the relationship. Analysis of data is ongoing.

### **BRAZIL: CHILDBEARING FROM BEGINNING TO END**

In Brazil, two topics were identified as important for WSP research: the consequences of adolescent pregnancy and the prevalence of female sterilization as a contraceptive method.

Contraceptive use rates in Brazil are among the highest in Latin America (66 percent). The pill and sterilization are the most frequently used methods, although condoms, injectables and IUDs are available. Oral contraceptives can be obtained over the counter from pharmacists, which has raised the concern that users may not receive adequate counseling or education.

Sterilization, which was not officially recognized as a family planning method until 1997, is prevalent among young women, of the women who have been sterilized, 57 percent underwent the procedure before age 30, and 34 percent of the women seeking sterilization have only two children. Although contraception is popular, access is limited among certain groups — women in rural

## FINDINGS AND IMPLICATIONS FOR

■ Many pregnant teens considered abortion to terminate their pregnancies, and the drug Cytotec was widely recommended to them by relatives and friends. Policy-makers and health providers should consider mass media educational campaigns, emphasizing the need for sexually active teens to use contraception. In addition, policy-makers should ensure that a wide array of contraceptive methods are available. Such efforts could be one way to prevent unplanned pregnancies and to reduce abortion among adolescents.

■ For many teens, pregnancy brought short-term improvements in their lives. Adolescent mothers had increased levels of self-esteem and improved relationships with their mothers. For many young women, pregnancies were planned and wanted. Policy-makers need to explain that there are also negative consequences of adolescent pregnancy — specifically, young women must interrupt their education, which can have a potentially negative effect on their future financial security. To encourage adolescents to delay first pregnancy until they have completed school, policy-makers must increase options for young women, so that motherhood is not their only means of achieving status and recognition. Policy-makers must make available additional education and employment opportunities, and encourage young women to view school as a means of achieving autonomy.

■ Most women who have undergone surgical sterilization are happy with their choice. However, WSP research reaffirms the findings of previous studies that young age may lead to sterilization regret. Health workers need to emphasize that women who are under age 30 may regret their choice to end childbearing, and women need to understand that sterilization is not easily reversible. Brazil's Congress has recently legalized sterilization for family planning, and the law emphasizes counseling, which will be especially important to help women make informed choices about the contraceptives that are best for them.

■ Policy-makers should promote and increase the variety of methods available to women and men in Brazil. As this occurs, health workers must provide thorough counseling on methods, including counseling about how methods affect STD transmission, to help women and men make informed choices.

■ Women do not view changes in their menstrual cycles resulting from contraceptive use as significant. However, changes do occur, and for some women, these can be problematic. The extent and nature of menstrual changes, especially changes following sterilization, are issues for future research.

areas adolescents and men. And while abortion is illegal except in cases of rape, incest or danger to the mother's life, estimates are that one to four million women have abortions annually — a life-time abortion rate of one to three per woman. Cytotec, a drug used to treat digestive problems, is often purchased on the black market and has been used in the past decade by women to induce their own abortions.

Of the 165 to 170 million people living in Brazil, 31 million are teenagers, and more than half of all adolescents live in poverty. Studies have shown that most Brazilian teens do not use contraception the first time they have sex, placing them at risk for unplanned pregnancies and sexually transmitted diseases, including AIDS. A survey in three major cities found that 6 percent of women ages 15 to 17 reported at least one pregnancy. Among 18 to 19 year olds, the percentage was 17 percent. Of the estimated one to four million abortions annually in Brazil,<sup>4</sup> one-fourth are thought to occur among adolescents.<sup>51</sup>

### Adolescent Longitudinal Study: Social and Behavioral Consequences of Pregnancy Among Young Adults in Fortaleza, Ceará

This WSP subproject explored the consequences of adolescent pregnancy on two groups of women: a group of 367 women who came for prenatal care at the adolescent clinic at Maternidade Escola Assis Chateaubriand (MEAC) in Ceará and a group of 196 women who came to the emergency ward for treatment of incomplete abortion (either spontaneous or induced).<sup>52</sup> Researchers from MEAC interviewed the women during their initial visit to the hospital, 45 days postpartum or post-abortion, and one year after a postpartum or post-abortion visit. Prenatal teens were also interviewed at their thirty-fifth week of pregnancy.<sup>53</sup> The goals of the longitudinal study were to explore adolescents' perceptions of the impact of the pregnancy on their personal well-being, their schooling or employment, and their relationships with family and partners.

A baseline comparison shows differences in age, sexual history, relationship status and family

<sup>†</sup> Results from final interviews with abortion and prenatal teens were not available at the time this report was published.

reaction between prenatal teens and those seeking treatment for abortion. More than half the prenatal teens were 16 or younger, while one third of the abortion patients were in this age group. About half the prenatal group were married or living with a partner, while only 7 percent of the induced abortion patients were in union. Induced abortion patients were more likely to work for pay. On average, teens in both groups had completed less than six years of schooling. At 45 days postpartum or postabortion, school enrollment overall had declined from 50 percent to 30 percent. Among the prenatal teens, 35 percent said they quit school because of their pregnancy, but some two thirds of adolescents who terminated their pregnancies were still in school.

Contraceptive use at the time young women became pregnant was low — 12 percent of the prenatal group and 16 percent of the spontaneous abortion groups. Contraceptive use was slightly higher for the induced abortion group — 23 percent.

Another difference between the prenatal and aborting teens was in their perceptions of how pregnancy would affect their lives. Prenatal teens said they, their family, friends and partners were pleased with the news of the pregnancy, in sharp contrast to aborting teens, many of whom said their loved ones did not know they were pregnant. Abortors thought pregnancy would threaten their education, ability to earn money, family relations and social life. Prenatal teens, on the other hand, thought pregnancy would improve their relationship with family, friends and their partners. At 45 days postpartum, adolescent girls reported that relationships with their mothers had improved, but relationships with partners had deteriorated for prenatal and aborting teens.

Differences between the two groups were evident in their discussions of desire for and timing of pregnancy. Almost half the prenatal teens said they wanted to be pregnant, while only 13 percent of the induced abortion patients gave this response. When asked if they would have preferred to delay pregnancy, 60 percent of prenatal group said yes, compared with 91 percent of the abortion group. Abortors had lower self esteem than did prenatal teens, however the first group had a greater sense of autonomy and locus of control. At

45 days postpartum, self esteem among teenage mothers had significantly increased. Self esteem also increased among teens with induced abortions but was low in comparison to the prenatal group.

To understand the decision making process of the young women in both groups, researchers asked if anyone had suggested they terminate their pregnancy. More than half the prenatal group said yes, that their friends, mothers, partners or other relatives had suggested they end their pregnancies. (See Table 9, page 86.) One quarter of the prenatal teens actually did attempt abortion, using herbal teas, Cytotec and other drugs. Forty nine percent of the teens in the induced abortion group said someone suggested abortion to them, and 80 percent used Cytotec. The results of this study and others show that Cytotec is widely used as an abortifacient in Brazil. Although the drug was banned in Ceara state in 1991 and is available in other states only with a double prescription, the drug continues to be available on the black market.

Researchers concluded that the short term consequences of adolescent childbearing are not all negative. Furthermore, an adolescent's perceptions of her self are strongly influenced by her family and peers. For both the prenatal and aborting group, relationships with parents may be more important than relationships with partners, researchers found. Abortors, who were interviewed at a time of great stress and who received little emotional support from those around them, were unhappy about the pregnancy and had lower levels of self esteem, while the new mothers in the prenatal group reported increased levels of self esteem. Researchers will analyze data from interviews at one year postpartum and postabortion, looking for changes in self esteem and teens' perceptions of their pregnancy.

### **Consequences of Tubal Ligation for Women's Lives**

The high prevalence of sterilization in Brazil has given rise to questions about the quality of reproductive health services as well as the quality of women's lives. This study found little difference in the perspectives of women who had been sterilized and those who used another contraceptive.

The Centro de Pesquisas das Doenças Materno Infantis (CEMICAMP) surveyed 476 women —

**TABLE 9 Brazil Adolescents' Attitudes Toward Pregnancy Termination**  
(in percent)

	Outcomes of Pregnancy		
	Prenatal Care	Spontaneous Abortion	Induced Abortion
<b>Was termination recommended?</b>			
Yes	53	43	49
No	47 (n=370)	57 (n=82)	51 (n=113)
<b>By whom?</b>			
Friends	48	46	29
Mother	20	6	27
Other Relatives	23	31	20
Partner	9 (n=196)	17 (n=35)	24 (n=55)
<b>Did you consider termination?</b>			
Yes	23	8	66
No	77	92	9
Medical chart said induced abortion			12
At second interview abortion reported as induced	(n=369)	(n=83)	13 (n=114)
<b>Method of induction?</b>			
Took Cytotec <sup>†</sup>	24		80
Took other pharmaceuticals	15		8
Used teas	59		11
Other method used	3 (n=34)		1 (n=74)

† Cytotec a drug used to treat digestive disorders is sold illegally as an abortifacient

half of whom had undergone sterilization and half who had not.<sup>83</sup> The women were ages 30 to 49 living in low to middle income neighborhoods in Campinas, São Paulo. Interviews were conducted five or more years after tubal ligation, and women from the two study groups were matched by place of residence and age. Prior to the survey, researchers conducted focus group discussions to determine how women defined the psychosocial variables that were to be examined in the study—self esteem, well being, marital satisfaction, and balance of power within a sexual relationship.

Investigators found that the two groups of women were similar in many respects: age (average age was 42), ethnic background (72 percent were white, 16 to 19 percent black), religion (35 to 36 percent were practicing Catholics, while 14 to 20 percent were Protestants), and work status (46 percent worked outside the home). However, there were differences. Among working women, non-sterilized women appeared to have higher per capita income, although sterilized women reported higher family incomes. Non-sterilized women were more likely to be single. On average, non-sterilized women reported 1.2 live births, compared with three births among sterilized women. Sterilized women also had their first births earlier than did non-sterilized women.

In discussing their experiences with tubal ligation, the majority of sterilized women said they were happy with their method choice. Ninety percent said they were satisfied, and their three most frequently cited reasons were they had reached their desired family size, the method was effective, and it was safe. By comparison, 79 percent of the non-sterilized women were satisfied with their method choice, the most frequently cited reasons were that their method was safe, it was effective, and it helped them achieve their ideal family size.

When sterilized women were questioned about method dissatisfaction, age was a factor, and age affected women's perceptions of regret. Sterilized women under age 25 were more likely to be unhappy with their contraceptive choice than women 25 and older. Eighteen percent of women under 25 said they regretted their decision, while

17 percent of those ages 25 to 29, and 9 percent of women 30 or older reported regret. These numbers were so small that researchers did not find them statistically significant, however, the findings did support previous research on the relationship between age and regret.

Given the prevalence of sterilization, non-sterilized women were asked why they had not chosen this contraceptive. More than 100 women said they had considered, but not undergone, tubal ligation because they could not afford the operation, a health provider refused to perform the procedure, saying the woman was too young or had too few children, they feared surgery, or their partner objected.

Women were asked whether they perceived changes (physical or emotional) since they began using contraception. Physical changes were often viewed as negative while non-physical changes attributed to contraceptive were seen as positive. Sterilized women most often reported a change in their menstrual cycles, 48 percent of women experienced such changes, and 23 percent characterized the changes as positive. Among non-sterilized women, only 28 percent reported menstrual changes from their contraceptive method. 59 percent considered these changes positive.

In most of the other situations investigated (relationships, work outside the home, studies, economic conditions, self-esteem), there were no significant differences between the sterilized and non-sterilized women except for the impact women perceived their method had on their economic situation. Twelve percent of sterilized women reported a change, and 97 percent said it was positive. Only four percent of non-sterilized women reported that their method had contributed to their economic situation, more than half of whom said the change was positive.

Researchers concluded that women generally are satisfied with their chosen method — whether sterilization or another contraceptive. Most women do not perceive that family planning had any impact, positive or negative, on the quality of their lives.

## JAMAICA GIRLS, BOYS AND THE GENDER GAP

In Jamaica, most adolescents know about family planning — however, awareness does not translate into action. In the 1993 Contraceptive Prevalence Survey, 95 percent of young people could identify two or more contraceptive methods. However, Jamaica's adolescent pregnancy rates are among the highest in the Caribbean. Forty-five percent of all Jamaican women ages 15 to 24 have been pregnant by age 19, and 41 percent have given birth.<sup>84</sup> Among sexually experienced youth, fewer than half the women (43 percent) and 22 percent of the men used contraception at first intercourse.<sup>85</sup> The consequences of early, unplanned pregnancy — especially the difficulty of remaining in school and the potential loss of job skills — place women at a distinct socioeconomic disadvantage.

Improving adolescent reproductive health is one of the Jamaican government's top priorities. The government plans to strengthen its family life



ELI ABETH EGLESTON/FHI

*Adolescent girls in Jamaica said sexual activity for their age group was taboo, while adolescent boys said sexual activity would bring increased status among their peers.*

education program and improve access to reproductive health services for young people, with the hope that one outcome will be a reduction in teen pregnancy rates.

Data from previous studies indicate that some (but not most) adolescents are sexually active in their early teens, and consequently at risk for unplanned pregnancy and STDs. To learn more

## FINDINGS AND IMPLICATIONS FOR

■ Given that 12-year olds in the WSP focus group discussions had some knowledge about sex, contraceptives and STDs — and given that a majority of boys and some girls reported in the questionnaire that they were sexually experienced — family life education programs should begin before puberty. Young people need to have accurate information, which many of them lacked, about the health, emotional and economic risks of unplanned pregnancy.

■ Family life programs must take into account the tremendous role gender norms play in shaping young people's attitudes and behaviors.

■ Family planning programs should recognize that many adolescents are sexually active, and programs should make contraception and other reproductive health services more accessible to young people.

■ Information, education and counseling should reinforce teens' own views that young people should get an education and a job before they become parents.

■ Policy-makers should continue their strong commitment to address the issue of teen pregnancy.

■ Programs to help adolescent mothers return to school, such as the island-wide program administered by the Women's Center of Jamaica Foundation, should be expanded.<sup>88</sup>

about young adolescents' knowledge, attitudes and behaviors with regard to sexuality, reproduction and family planning, the WSP conducted a three-year longitudinal study. This study was the first in Jamaica to examine sexual and reproductive knowledge, attitudes and behaviors among adolescents under age 15. A secondary WSP goal was to evaluate the Grade 7 Project's impact on young adolescents' reproductive knowledge, attitudes, behaviors and contraceptive use. Begun in 1994 by the Women's Center of Jamaica Foundation, the Grade 7 Project is part of the Center's Program to Delay First Pregnancy, an in-school family life education program implemented from 1994-96. (The evaluation of the Grade 7 Project was not completed at the time this report was published.)

Data were collected from 945 young people, considered at high risk for early pregnancy. The students, whose mean age was 12.2 years when they entered the study, completed a questionnaire at school at three different points in time. In addition, 16 same-sex focus group discussions, which each included 32 participants, were held in two urban areas and two rural areas. Eight focus group discussions — four with boys and four with girls — were held in 1996, and eight were held in 1997. In the first focus group discussions, Grade 7 students were asked to comment on a hypothetical situation involving an adolescent boy and girl. (See Table 10, page 89.) In addition to this study, the WSP also conducted a case study of a women-centered health program in Jamaica.<sup>88</sup>

Perhaps more than any study in the WSP, this research project underscores the tremendous influence of gender norms in shaping sexual knowledge, attitudes and behaviors. Researchers found that messages about sexual behavior are internalized at an early age. Girls are taught that early sexual activity is something secret and shameful, while boys are taught that sex is something that brings pleasure and status.

<sup>†</sup> Parents gave permission for their children to participate in this study and students were assured of confidentiality.

In 1995, sixty four percent of the boys surveyed said they had had sexual intercourse, while only 6 percent of girls gave this response. Among those reporting sexual activity, the mean age for first sex was 9.3 years for boys and 12.4 years for girls. Most boys saw saying no to sex as primarily the responsibility of the girl, and many said their willingness to delay first sex would depend upon the girl's point of view. "Me would think about it until she ready fi say yes," said one boy. "She want to have sex with me? Sir, me would have sex!" said another.

When they completed the questionnaire, curiosity and love were the most common reasons adolescents gave for having sex. (However, in focus group discussions, no boys mentioned love as a reason for first sex.) More than two thirds of the boys and one third of the girls agreed that "if you really love your boyfriend/girlfriend, you should have sexual intercourse with them." However, other reasons were more complex. In 1995, nearly half the boys and 14 percent of the girls said that if a boy "spends a lot of money on a girl," she is obliged to have sex with him.

When asked how they would feel after losing their virginity, girls tended to describe negative feelings — "sad" or "embarrassed" — while boys said loss of virginity was a sign of maturity and status. "Him feel that him is a man now," said one boy. Girls said they would not tell their family or friends if they became sexually active. "Them would call her *sketel* [slut]," said one girl. Conversely, boys said they would brag about their sexual experience to their peers. "Him a go tell him friend, big brother. Him tell him relative and cousin and friend and everybody!"

In focus group discussions, young people demonstrated high awareness of family planning, and some spontaneously suggested that teens use contraception — particularly condoms — if they were sexually active. Teens even knew that they could get condoms at the pharmacy, from a doctor, or at a health clinic. Among teens who were sexually experienced, 65 percent of the girls and 30 percent of the boys reported using contraception at first intercourse, the condom was the most frequently used method.

However, young people had limited *accurate* knowledge about contraception, according to data from the questionnaire. For example, some teens believed they could prevent pregnancy by having sex while standing or by drinking a cola soft drink after sex. Teens were keenly aware of HIV and other sexually transmitted diseases, and 78 percent of boys and 57 percent of girls knew that condoms could prevent STDs.

On the questionnaire, some adolescents said that contraceptives were used only by teens with multiple partners. In focus group discussions, however, adolescents expressed positive attitudes about contraception and agreed that



**TABLE 10 Jamaica Young Adolescents' Reproductive Health Knowledge, Attitudes and Behaviors**

	Girls	Boys
Mean age at first sex	12.4 years (n=51)	9.3 years (n=251)
Mean age difference with first sexual partner	2.9 years	1.2 years
Percent reporting sexual activity in September 1995 (n=926)	6	64
Percent reporting sexual activity in June 1997 (n=713)	13	75
Percent who used family planning at first sex	65 (n=51)	30 (n=250)
Percent who agree with the statement "If you really love your boyfriend/girlfriend you should have sex with him/her"	32/24 <sup>†</sup>	69/57 <sup>†</sup>
Percent who agree with the statement "If a boy spends a lot of money on a girl she should have sex with him"	30/14 <sup>†</sup>	58/46 <sup>†</sup>
Percent who agree with the statement "It is okay for a girl to have sex with a boy who is not her steady boyfriend"	4/3 <sup>†</sup>	18/18 <sup>†</sup>
Percent who agree with the statement "It is okay for a boy to have sex with a girl who is not his steady girlfriend"	5/3 <sup>†</sup>	28/31 <sup>†</sup>

<sup>†</sup> The first number represents the percentage of students in Grade 7 surveyed in September 1995. The second number represents students surveyed in Grade 8 in June 1997.

use of family planning indicates responsible behavior. At the same time, they also said contraceptives are an admission of sexual activity, which was taboo for young girls. One girl said, "They would say she taking it [the pill] 'cause she having sex a lot of the time." A few boys also said they would be reluctant to use a condom because it would diminish their own sexual pleasure and their status among peers. "Them say it not nice with the condom," said one boy. "Him no tell nobody because them a go laugh at him and say him a little boy," said another.

Boys and girls said they would be anxious or scared if they had an unplanned pregnancy. A pregnant girl "would feel happy in a way and sad in a way," said one young woman. One boy said, "The good ones [peers] would ask him why him do such a thing, him should've wait. But

## MIDDLE EAST AND AFRICA

### EGYPT FAMILY PLANNING'S EFFECT ON CLIENTS, EMPLOYEES

When looking at reproductive health in Egypt, there are numerous dichotomies. Contraceptive knowledge is widespread and approval is high, but contraceptive use is limited, particularly in rural areas. Although two thirds of married women say they have used contraception at some point in their lives, new DHS data indicate that current use is 56 percent. Three in 10 women stop using a method within a year of starting, according to the DHS. In addition to desire to become pregnant, the main reasons for contraceptive discontinuation are method failure, concern about side effects, and concern about overall health.<sup>86</sup>

The pill and the IUD are the most commonly used methods of contraception, 10 percent and 30 percent respectively. But the rates of contraceptive failure and unintended pregnancy are high — 18 percent for pill users, 14 percent for IUD users, and more than 30 percent for users of condoms, vaginal methods (spermicides) and withdrawal. Although 58 percent of women say they live within 30 minutes of a clinic or another facility where they can obtain contraception, 16 percent of married women, most living in rural areas, say they need contraception but do not use it.<sup>87</sup>

In Egypt, family planning occurs in the context of strong cultural and religious norms (Islam) that govern individual behaviors. Although the legal age for marriage is 16, 20 percent of women are younger than 16 when they marry. Eighty percent of women say their marriages were arranged. Women and men have equal rights under the law, except in the home. Female circumcision is widely practiced in Egypt, 97 percent of women say they have been circumcised, and 82 percent said they support the practice.

In Egypt, the WSP supported two major studies to explore the impact of family planning on women's lives. One, conducted by the Social Research Center at American University in Cairo, focused on family planning users. The second was conducted by the Cairo Demographic Center and looked at family planning from a different

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*Female family planning workers in Egypt said they enjoyed their work but felt stress because of job demands and responsibilities at home.*

the bad ones would big him up and say 'gwan man, you get a son!' and them would want to try it." Most survey respondents saw parenthood as a major economic and emotional responsibility, and 70 percent thought a pregnant girl should be allowed to return to school after her baby was born.

perspective — that of women who work in family planning programs

The WSP also provided technical assistance to four smaller studies. The High Institute of Public Health examined family planning use among married adolescents in squatter areas of Alexandria, while the Faculty of Medicine at Assiut University studied the knowledge, attitudes and behaviors of youth in Upper Egypt. A third study was conducted by the Cairo Demographic Center and focused on women's perceptions of the consequences of unplanned pregnancy. The Faculty of Nursing at Alexandria University studied women's views of differences between treatment of male and female children within the family. Results are being analyzed and will be posted on FHI's web site as they become available.

### **The Role of Women as Family Planning Employees in Egypt**

The primary goals of this study were to describe women's participation in family planning programs and to examine women's perceptions of family planning work and its effects on their own health status, self-esteem, economic resources, family relationships and public standing.<sup>90</sup> To do this, researchers analyzed statistical data from the country's six largest family planning organizations — the Coptic Evangelical Organization Social Services (COSS), Clinical Services Improvement (CSI), the Egyptian Family Planning Association (EPPA), the Health Insurance Organization (HIO), the Ministry of Health and Population (MOHP), and the Teaching Hospital Organization (THO).<sup>†</sup> Employees included in the analysis were physicians, nurses, social workers and *raedat icfiat* (field workers).

Additionally, 16 focus group discussions were conducted in each of four governorates: Cairo, Kafr El Sheikh, Beni Suf and Sohag. Participants were selected to represent four occupations (physicians, nurses, social workers and *davas*), urban and rural locations, and length of experience (less than five years versus five years or more). Finally, in-depth interviews were held with 19 leaders in Egypt's family planning program.

## **FINDINGS AND IMPLICATIONS FOR**

■ **There has been much discussion in the reproductive health community, urging family planning programs to make their client services more gender-sensitive — to consider the cultural norms that affect women's access to and use of services. Family planning programs might also consider the need to make their programs more gender-sensitive for employees. WSP researchers recommended that, because of the high number of female employees, programs should consider strategies to accommodate women's dual burden of work and homemaking chores. Programs should work with employees to help them balance their dual roles, with the aim of helping women achieve greater personal satisfaction and gender equity.**

■ **An ongoing debate in Egypt is whether increasing the number of female physicians working in family planning clinics would lead to greater use of contraceptive services. Research findings from this WSP study show fewer female physicians providing family planning than working in other health services. Also, there is a lower percentage of female physicians working in family planning services at the MOHP, which serves the largest number of clients. The MOHP is considering ways to bring more female physicians to its family planning programs, particularly in rural areas where the needs are greatest, and researchers recommended this effort continue.**

■ **Given the high failure rates for contraceptive use, more education and counseling are needed for couples who want to delay, space or end childbearing. Counseling on correct pill taking, how to check for the presence of IUD strings, and the use of the lactational amenorrhea method (LAM) would be especially useful. Health workers should also receive additional training to improve counseling skills and keep up-to-date on scientific information.**

■ **Because older women and high parity women are more likely to want to postpone or end childbearing, special attention should be given to the needs of this group.**

■ **Because of their influence on women's contraceptive use and family size, men should be involved in family planning education programs.**

<sup>†</sup> *Davas* (traditional birth attendants) were not included in this analysis because they are not officially employed by family planning programs.

In analyzing statistical data, researchers documented that the MOHP was by far the largest employer of family planning workers (87 percent) in country. The EFPA employed 7 percent of paid workers, while the remaining four organizations employed less than 3 percent each. Among family planning workers, nurses comprised the largest category (30 percent), while physicians and *raedat refiat* each accounted for one quarter of family planning employees. Of the 19,610 employees in Egypt's six family planning organizations, 82 percent were female. Forty eight percent of physicians were women, although the percentage varied widely by organization, ranging from a low of 13 percent to a high of 93 percent.

When questioned about the impact of family planning work on their personal lives, female employees spoke of stress and role conflict. Women in all occupations felt they had too little time to take care of their families or their own needs. Women worried about sick children, house work and child care. Women also said they felt stress because of lack of adequate material resources to perform their jobs. Physicians and nurses in Cairo said they received no extra pay when they were required to work in afternoon clinics because of client overload — but they did receive criticism from their husbands and children about being away from home. One leader said her family life had suffered because of travel in and out of Egypt. The dual demands of work and home left women with little time for participation in community activities.

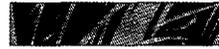
Nonetheless, most women were proud of their jobs and satisfied with their work. Study participants felt that a great benefit of family planning work was learning new skills, such as counseling, IUD insertions or infection control. In addition, women felt their work in family planning programs gave them an increased personal understanding of people's lives and their community's needs. One social worker said that without family planning work, "I would not have seen the true

problems of life." Women also cited their work with other women — something their husbands approved of. Except for social workers, most study participants and their spouses were pleased with the additional income and community respect gained by work in family planning programs.

Study participants said their work had increased their autonomy and enhanced their role in household decision making. Through their jobs, they had obtained knowledge and confidence, which helped them make decisions with their husbands, including decisions about daughters' age at marriage, premarital medical examination for daughters, and women's own contraceptive use. A physician in rural Beni Suef said that her work "encouraged me to use contraception and made me know about the advantages and disadvantages of each method and helped me choose the right method."

Study participants said their work outside the home brought new respect inside the home. Said one woman in Kafr El Sheikh, "We deal with different segments of the community, and we can see ourselves the negative results of non-education and the low standard of some rural schools. Working in family planning gives me the confidence to share in these decisions [about children's education]." A social worker in Sohag said, "The word 'planning' does not apply to contraception only, it applies to planning in every aspect of family life." Women said they had control over how they spent their own money, and most spent it on children's needs and items for the home.

Study participants also said that work achievements enhanced their self-esteem. A doctor in Beni Suef said, "I have developed more confidence through the trust of clients in keeping their secrets." However, some workers were hurt by criticisms leveled at them for stepping outside traditional women's roles. Nurses in Sohag said their profession had a poor image, and social workers in Upper Egypt said they were not respected in their communities. Clients' relatives blamed family



*"The word 'planning' does not apply to contraception only, it applies to planning in every aspect of family life."*

**Egyptian family planning worker**

planning workers for contraceptive side effects "Some men say bad words and some husbands and mothers of clients do not meet us nicely and quarrel with us if anything happens as a result of using contraceptives," said a social worker in Upper Egypt. Ironically, for some, opposition helped build their self esteem. "Working in family planning is like swimming against the tide," said one family planning leader. "This is what creates a leader because it needs great effort and strong character."

When questioned about decision making in the home, most women said decisions should be made jointly by husbands and wives. However, study participants said husbands' opinions most often prevailed when there was a disagreement. Nurses in the more politically conservative areas of Sohag and Kafr El Sheikh said they consulted with their husbands out of "religious necessity," and some social workers in Cairo said their mothers in law insisted on helping make decisions. Most women said they obtained their husband's permission before leaving their home, although this was not a problem in their work.

### Social and Behavioral Outcomes of Unintended Pregnancy

Children born as the result of unplanned or unwanted pregnancy start life at a disadvantage and face numerous health and social problems throughout childhood. Previous studies (outside Egypt) have shown that unplanned children have lower birth weights, do not grow as tall and are more vulnerable to death than planned or wanted children. Unplanned children, especially girls, have lower education levels and poorer socioeconomic conditions, and appear to suffer moral and social problems due to parental neglect.

In Egypt, no studies had been done on this topic prior to the Women's Studies Project. This WSP study analyzed statistical data from the 1993 Egypt Use Effectiveness of Contraception Survey (EUECS) and the 1997 Social and Behavioral Outcomes of

Unplanned Pregnancy Survey (SBEUPS) to determine demographic and socioeconomic characteristics of women with unplanned pregnancies and to examine changes over time.<sup>91</sup> Data were analyzed from more than 1,700 study participants who reported an unplanned pregnancy. In addition, women participated in a qualitative survey to explore their perceptions of how the unplanned pregnancy affected their own lives and the lives of their children and families.

Analysis of the EUECS and SBEUPS data found that older women were more likely to report an unplanned pregnancy than their younger counterparts. In addition, women with unplanned pregnancies were more likely to work outside the home, but there were no differences in education or residence.

Contraceptive use increased in Egypt from 1993 to 1997, ironically, most unplanned pregnancies occurred among contraceptive users. Sixty two percent of women with an unplanned pregnancy became pregnant while using a contraceptive method. Contraceptive failure was highest among pill users (57 percent), followed by the

LAM, the IUD (16 percent), and other methods, such as condoms and spermicides (13 percent).

Thirty eight percent of women were using no method at all, even though they did not want to become pregnant. Reasons for non use were "having a rest" (57 percent), believing they could not become pregnant (21 percent), believing they were infertile (17 percent), husband was away from home (7 percent), fear of contraceptive side effects (6 percent), and husband's opposition (3 percent).

Although abortion is illegal in Egypt, one third of women reported trying to terminate a pregnancy. Age and parity affected attempted abortion rates. The percentage of women who attempted abortion was lowest among women younger than age 20 (23 percent) and highest among women 35 or older (36 percent). Rates of attempted abortion were highest for women with



*"Some men say bad words and some husbands and mothers of clients do not meet us nicely and quarrel with us if anything happens as a result of using contraceptives."*

Family planning worker in Upper Egypt

five or more children (approximately 35 percent). As expected, women who wanted to end child bearing were more likely to attempt abortion than women who wanted to space or delay pregnancy. Women with a secondary education were less likely to seek abortion than women with no schooling (19 percent versus 32 percent). In all geographic regions except the Urban Governorates, women were most likely to seek help from a physician in terminating a pregnancy. Forty-four percent of women said they saw a doctor but were refused help, 21 percent consulted a physician who gave them medications, 35 percent used traditional abortion methods, and 15 percent tried a combination of modern and traditional methods.

Attitudes about unplanned pregnancy differed between men and women (See Table 11, this page). While women in this study did not want to be pregnant, 42 percent of men said they were pleased about the pregnancy, 25 percent said they were neutral, and 35 percent did not want the pregnancy. Among men who were happy about their wife's pregnancy, the main reason was fondness for children. Among couples who did not want another child, the main reasons given were the high costs of bringing up a child, the need for parental time and attention, women's health problems that might negatively affect the child, and "bad" timing. Not surprisingly, because of gender norms that prescribe men as the provider and women as the nurturer, mothers were more likely to be concerned about the amount of time they would devote to the child, while fathers were more likely to be concerned about financial support. Among couples with children of the same sex, concern about having another same sex child was cited as a reason for postponing pregnancy. Couples expressed a stronger preference for boys than girls.

However, researchers also learned that, in the long term, women do not necessarily view an unplanned pregnancy as an unwanted pregnancy. Once a child was born, women said they made no distinction among their children, whether the pregnancy was planned or not. Nearly 80 percent of women said their unplanned children received the same prenatal care as other siblings. The majority of women (70 percent or greater) reported no differences in immunizations, breastfeeding practices, birth weights or place of delivery. Nearly 60 percent of parents said the unplanned child received the same amount of affection as other children in the family, while 38 percent said the child received more affection.

#### **MALI THE RISKY BUSINESS OF CONTRACEPTIVE USE**

In Mali, as in many other African countries, contraceptive use is low. Although family planning has been part of official Malian policy since 1972, only 6.7 percent of married women use any contraceptive method, and less than 5 percent use modern methods, according to the 1996 DHS.<sup>9</sup> Levels of

**Table 11 Egypt Social and Behavioral Outcomes of Unintended Pregnancy**  
(in percent)

Reasons for not wanting pregnancy	Mother (n=1 783)	Father (n=1 766)
Expense, cost of living	61.0	80.0
Infant's demand for time and attention	40.0	26.0
Mistimed pregnancy	5.0	9.5
Advanced age of mother	2.8	1.8
Health problems for mother, fetus	23.0	12.0
Too many girl children	2.3	1.9
Too many boy children	0.9	0.6
<b>Feelings about unplanned pregnancy</b>		
Pleased	3.2	41.9
Indifferent	9.1	22.9
Upset	74.0	35.2
Resigned to God's will	13.7	—

use are higher in urban areas, for example, in Bamako, 16.4 percent of women use family planning compared with 8.2 percent in other cities and only 1.9 percent in rural areas. Among women who use family planning, discontinuation is high. An earlier study of nearly 900 women, conducted by the Centre d'Etudes et de Recherche sur la Population pour le Développement (CERPOD), found that two thirds quit using a method within 15 months of starting.

Although contraceptive use is minimal, attitudes about family planning among married women are generally positive. Nearly three quarters of women approve of family planning, reports the 1995 *Enquête sur la Promotion du Logo National de la Planification Familiale*.

Gender and religious norms may discourage contraceptive use. Mali is a strongly patriarchal culture, which delegates authority and decision making to men and elder female relatives, especially the mother-in-law. Younger women have little autonomy over their bodies, their mobility, and their finances. Polygamy, which is still practiced, discourages contraceptive use when wives compete with each other to produce children. According to the DHS, 10 percent of women said contraceptive use conflicts with Islamic religious beliefs. A 1996 study found that one fourth of couples said they had never discussed family planning, and one in five couples disagreed about family planning (the husband disapproved but the wife approved).<sup>9</sup>

To learn more about women's contraceptive decision making, the WSP worked with CERPOD to conduct a prospective survey of 55 new contraceptive users.<sup>10</sup> Women were interviewed during their initial visit to the Association Malienne pour la Protection et Promotion de la Famille (AMPPF), the International Planned Parenthood Federation affiliate, then were re-interviewed at eight months and again 18 months later. After loss to follow up, 41 women participated in the second round of interviews. Additionally, four focus group discussions were conducted with mothers-in-law, four with experienced contraceptive users, and three with husbands. In each category, separate groups were held for educated and non-educated participants.

## FINDINGS AND IMPLICATIONS FOR

To learn more about women's contraceptive decision making, the WSP worked with CERPOD to conduct a prospective survey of 55 new contraceptive users.<sup>10</sup> Although the study population here is small, researchers believe findings can be used to initiate discussions on changes in health policies and programs.

- Because women, especially sisters-in-law, encourage each other's use of family planning, family planning organizations could incorporate peer networks or use peer educators in their outreach programs. Peer networks may be a way to urge non-users to initiate discussions about contraceptive use and to answer their questions. Peer educators also could educate women about contraceptive myths, which remain prevalent, and they might be able to help new users realistically anticipate and cope with side effects.

- Legally, Malian women do not need spousal consent to obtain contraception. However, as the statutory heads of the household, husbands' decisions about family planning use are critical to women's contraceptive practices. Programs should consider ways to educate men about the benefits of family planning, including the use of male peer education groups. In addition, policymakers may want to rethink laws that make the husband the final arbiter in decisions about women's health. For women whose husbands disapprove of family planning, providers should offer special counseling to help the woman resolve conflict and make a decision that is best for her.

- Programs also should consider how to reach groups other than married women, including single women and residents of rural communities.

- The health infrastructure in Mali should be strengthened to increase the supply of contraceptive methods available.



*"My sisters-in-law tell me to make every effort to go to the planning clinic."*

Malian woman

The study's goals were 1) to examine differences between what women expected from contraceptive use and their actual experiences, 2) to examine interaction between family members and communication between partners, 3) to explore the relationship between women's use of family planning and economic roles, and 4) to identify strategies women have developed to avoid or minimize negative consequences of family planning use

Study results showed that in Mali, family planning is considered by women and men to be a woman's domain, but both sexes regard decision making as the purview of men "It is he who rules, he is the only decision maker, he does not need anyone else's opinion," said one male focus group discussion participant "Only the man has the right to make the decision," said another This distinction between women's responsibility and men's right creates tension as women seek to plan their families When interviewed in focus group discussions, fewer than one third of men said they would ever need family planning

In focus group discussions, husbands were unanimous in their opinion that women had no right to use contraception without permission Some said the couple should make the decision jointly, but husbands were adamant that the final decision was theirs "When the husband says no, it means no," said one man "The woman can't say anything She must submit to her husband's decision " Another said, "If my wife makes the decision to use family planning without my consent, I will divorce her "

Most new contraceptive users said they had approached their husbands with logical arguments and examples of how family planning would improve the family's life However women also solicited the help of older sisters in law to broach the subject with resistant husbands and to encourage husband's support for contraceptive use "She [my sister-in law] asked me to speak about it first to my husband and if he refused, to have him talk to her, and she would make him understand," said one woman "My sisters in law tell me to make every effort to go to the planning clinic, that I don't see how much I suffer They also tell me, using jokes, that life is expensive, that they can't afford

more baptisms to let our little sisters bring the rest of the babies into the world "

Younger sisters in law did not play as critical an advocacy role, and mothers in law were considered of little importance in women's contraceptive decision making "As for my mother in law getting involved, this only concerns my husband and me He knows how much I have suffered, so no one should be interested more than the two of us," said one woman "All she could do would be to argue, and that's it," said another Husbands participating in focus group discussions agreed that mothers in law should not be involved in couples' contraceptive decisions Mothers in law themselves were reluctant to discuss contraception with daughters in law, but some said they would offer opinions in support of family planning if asked New users often regarded other elder female relatives, such as husband's aunts, as sources of support

For many women, the anticipated benefits of family planning were worth the anxiety they felt about confronting husbands For others contraceptive use became a clandestine activity Of the 41 new users, 17 did not tell their husbands at the time of their initial visit to the clinic At the time of the second interview, seven were still keeping contraceptive use a secret, three had abandoned family planning without telling their spouses, and two had told their husbands and encountered no problems Again, sisters in law and female friends and relatives offered encouragement One woman said, "He is not aware, and I don't want him to learn of it If he learns of it and makes a problem, I'll stop, but if he doesn't I won't stop "

Most clandestine users chose injectable contraceptives Others used oral contraceptives but hid their pill packets in bags and only took them out at night Others kept pills at a friend's house, while some women kept their pills at work "On holidays, I am nervous," said one woman "Each time he goes into the room, I tell myself he must have found them [pills] My heart beats faster until I take my pill in the morning "

Some women who used family planning without spousal permission said they faced anger,

  
" Even though they told me [about amenorrhea] to go all this time without seeing my period well, I wasn't really ready for that "

Malian woman

abandonment, divorce, and indifference to side effects. One clandestine user dropped out of the study when her husband discovered her contraception, threatened divorce, and then refused to let her leave the house.

New users encountered other obstacles, which led them to switch methods or discontinue altogether. Of the 41 new users interviewed eight months after they began using contraception, nine had discontinued family planning and two had changed methods. Concern about side effects was one reason. A Norplant user said amenorrhea and weight gain made her want to switch to another method. "Even though they told me I would go all this time without seeing my period well, I wasn't really ready for that."

For some new users, the continued cost of family planning was too great a financial burden. One woman, who quit using family planning after three months, said, "When all my pills were gone, I asked [my husband] to give me some more money. He refused, and I had no money left, which is why I didn't go back to the clinic. I would need round trip transportation as well as money for a new [pill] supply." (This comment represents a misperception of family planning service, which actually is provided at no cost after the first visit.)

Women's reasons for wanting to use family planning were that too many pregnancies and closely spaced pregnancies were a physical, emotional and economic burden. They described high parity in terms of "suffering," and chose family planning as a remedy. "The midwife told me that I should not have any more children, that it is not good for me," said one woman. "This coincides with my tenth pregnancy." Women also mentioned rest and health of the mother and child as reasons to space pregnancies. One woman said, "It is the first time I have weaned a baby before having another pregnancy." Said another, "The woman who has close pregnancies is exhausted, but when you space your children, you are at peace, it avoids sickness, you are always feeling healthy."

Women said family planning gave them the freedom to work both inside and outside the home. "When you are pregnant, and with a baby on your

back, the kitchen is dirty, you cannot clean," said one. "I can do my business as I wish, I can go where I wish," said another. Husbands and mothers in law also cited family planning as a vehicle that allowed women to work, and they approved of women bringing in extra family income.

While husbands were typically responsible for the family's expenses, most women said they managed the income they earned and enjoyed financial autonomy. However, many women contributed their money to the family. "In the past, there would be expenses for the children. If the father did not have the means, I would be obliged to pay," said one woman.

In addition to financial independence, family planning also offered women another kind of freedom — free time to devote to husbands and children. "I have sexual relations now with my husband, and I no longer have in my head that I am going to get pregnant," said one woman. "Because you have free time to take care of your husband, you can see the affection reborn," said another. "Your children will be well taken care of, they will eat as they should, you won't be tired or anything."

Among women in Mali who had never used family planning, most saw contraception as something that they might try once they had reached their desired family size. One woman said she would not consider family planning until she had her fourth child. Other non-users said they feared family planning would cause illness and infertility. While non users supported the idea of family planning, more than half said they had never discussed the issue with a spouse, friend or relative.

#### **ZIMBABWE FAMILY PLANNING, WOMEN AND DEVELOPMENT**

In Zimbabwe, four research subprojects were conducted to determine if and how family planning affects women as individuals and women as participants in the country's development process. Markers of participation in development were household decision making, work in the formal labor sector, and political and community activity.

Among sub-Saharan African countries, Zimbabwe has one of the highest contraceptive use



*" The woman who has close pregnancies is exhausted, but when you space your children, you are in peace, it avoids sickness, you are always feeling healthy "*

**Malian woman**

## FINDINGS AND IMPLICATIONS FOR

- Because many women report their first sexual experience occurs while they are students, sexuality, family life, gender education, and health education programs should be integrated into all levels of school curricula, including primary, secondary and post-secondary schools
- Policy makers should develop and promote a life-long education program leading to income generation for women, especially those whose educations were interrupted by pregnancy and childbearing
- Policy makers should consider ways to subsidize contraceptive programs so that costs are not a barrier to use
- Policy makers and health program managers should improve quality of services by making available a broader array of contraceptive methods and by increasing access to contraceptive services, particularly in rural areas. Programs also should improve counseling about methods and side effects, since concern about side effects can be a deterrent to family planning use
- Because men are viewed as heads of the household, and their views affect women's family planning use, family planning programs should involve men, including education programs and counseling specifically designed for men
- Many couples do not begin using family planning until after they have proven fertility or after they have reached their desired family size. Health programs should educate men and women that family planning can be used to space, limit or delay pregnancies, and family planning can be used early in reproductive life with no adverse effects on fertility
- To improve women's economic opportunities, governments and NGOs should help with the creation of more jobs for women. The public and private sector should provide jobs and skills training, plus access to credit. Primary, secondary and post-secondary schools should include family planning in career counseling programs for women
- Because women who use contraception at first sex are more likely to be employed, women should be educated about this link between reproductive and productive roles
- Parents' dependence on children and the common perception that large families are the only hope for security in old age is one factor that discourages family planning. Government leaders should study the costs and benefits of small pension plans, similar to those in neighboring South Africa, as a means of providing financial security for the elderly

rates. Family planning use increased from 10 per cent in 1980 to 48 per cent in 1994 according to the DHS. Fertility rates dropped from 6.7 children per woman in 1984 to 4.3 in 1994.

However, a gap remains between knowledge of family planning and use of contraceptive methods. Reasons include cultural values that support a large family and the unquestioned role of men as heads of households.

The past two decades have seen significant changes in the roles of women. Prior to 1964, when Zimbabwe was still governed by the British, women's roles were primarily to produce food and to bear children, since ownership of land was determined by lineage. Women were not permitted to own cattle, although they could own small live stock such as chicken or goats. During this time, women often became *de facto* heads of households as men migrated to work in mines or on commercial farms, but their status remained low. After Zimbabwe's independence, women's status began to improve, due in part to their participation in the country's struggle for the independence. The number of primary and secondary schools increased dramatically, as did the number of vocational education programs, opening new opportunities for women in the work force. Changes in women's legal status meant that, in theory, at least, women could receive the same pay as men for the same work, could own property, and were entitled to maternity leave from jobs.

However, while women have achieved some measure of autonomy in their work lives, they remain subordinate to men in the household. Cultural and gender norms define men as financial providers and women as homemakers; men's financial autonomy grants them authority in household decisions.

The Women's Studies Project in Zimbabwe sought to determine how family planning has helped women achieve their individual fertility goals. However, the Project also examined the larger issue of the effect of family planning on gender equity, including women's status, quality of life, vocational goals, and participation in the work force and the community.

### The Impact of Family Planning on Women's Participation in the Development Process

Through the use of life histories, this WSP subproject explored the relationship between contraceptive use and women's participation in economic development.<sup>97</sup> Researchers collected data on common patterns in women's reproductive lives, including contraceptive use and childbearing experience. In addition, they examined the association between reproductive life events and women's household activities, women's economic well being, and their ability to participate in the work force and in political and community activities.

Researchers analyzed existing DHS data on key variables (family planning use, family size, economic status) and conducted a new survey of 2,465 women, ages 15 to 49, in all 10 provinces. Survey results showed that reproductive life events for Zimbabwean women typically follow a pattern, with menarche at age 15, first sexual intercourse at age 18, marriage at age 19, and first birth at age 21. (As the age of menarche drops, the ages of first intercourse and first birth also are declining, researchers found.)

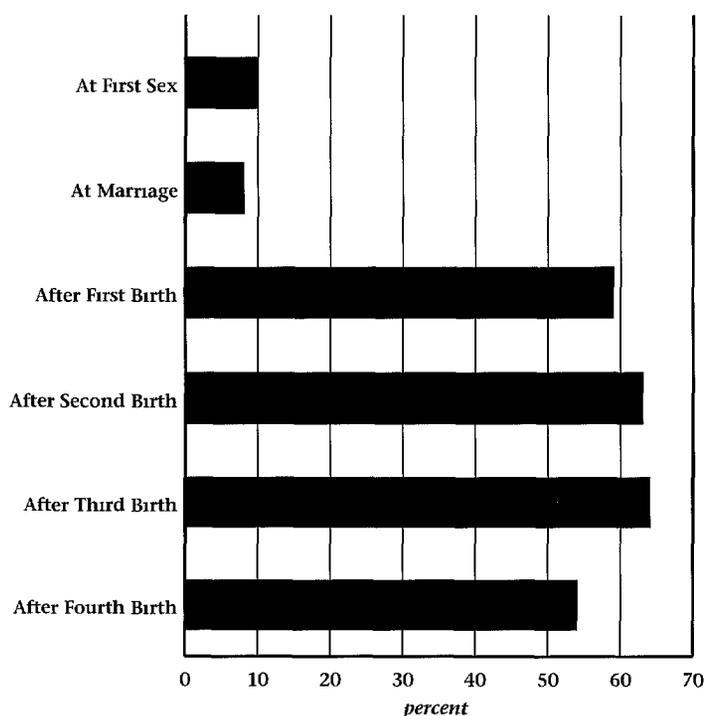
According to the 1994 DHS, 48 percent of women in Zimbabwe use family planning, and WSP research suggests this figure may have been even higher in 1997. However, contraceptive use typically occurs after the first birth, according to the WSP. Only 10 percent of women used family planning at first sexual intercourse and only 8 percent at marriage. Contraceptive use rose sharply after the first birth (59 percent of women) and increased again after second and third births (63 and 64 percent respectively). After the fourth birth, contraceptive use declined (54 percent). This pattern is similar for urban and rural women, a reflection of the cultural expectation that a woman must prove her fertility soon after marriage. (See Table 12, this page.)

Women who used contraception at first sex were more likely than non users to live in urban areas, to have some secondary schooling, and to have partners with more education. Women who used contraception were also more likely to report

their religion as Christian, viewed by many Zimbabweans as a sign of modernity. Some rural women, irrespective of parity, shunned contraceptive use. This group was comprised largely of women in remote areas with limited access to methods and services. For these women, side effects also were a deterrent to contraceptive use. Women in Chitsungo Ward in the Mashonaland



**TABLE 12 Zimbabwe Women's Use of Family Planning** (n=2 465)



East province, for example, said that oral contraceptives altered their menstrual cycles, gave them headaches, caused them to gain weight and reduced their libido. These women said they preferred traditional methods, such as withdrawal, which is less effective but has no side effects.

Women's role in contraceptive decision making appears to increase with parity. Approximately 30 percent of women said they jointly made decisions with their partners after first birth, but this figure increased to 36 percent after the third birth. However, family members often influenced women's contraceptive decisions. Women

in Masvingo province said spouses and in laws wanted them to bear numerous children to extend the family line

The WSP also found that women's participation in the formal labor force tended to be low — 32 percent of women work outside the home, a rate comparable to the percentage working in 1984. However, this finding must be interpreted in the context of Zimbabwe's current high unemployment rate

Women's work force participation was typically greater in urban areas than in rural areas. With more children, urban women felt increased pressure to work, while as rural women's parity increased, their labor force participation declined. Younger women were less likely to work than older women — 26 percent of women under age 30 worked, compared with 45 percent of women over 30. When compared with women who did not use contraception at first sex, women who did use contraception at first sex or first marriage were significantly more likely to use a method consistently thereafter and to be currently working

While women's work force participation was low, their participation in community activities was even lower. Six percent of study participants were involved in community activities at the time of first sex, and the figure rose only slightly, to 11 percent, after the fourth child's birth. Family planning use between births did not affect community participation. However, women who were involved in community activities at first sex tended to continue their participation intermittently throughout childbearing

Researchers concluded that although contraceptive use is high and fertility has declined, women remain only minor actors in the country's economic and political arenas. Family planning has helped women achieve their reproductive goals but has not become a gateway to participation in the development process

## Impact of Family Planning on Young Women's Academic Achievement and Vocational Goals

For girls in Zimbabwe, sexual activity typically begins in secondary school or college. Few women use contraception during first intercourse, placing them at risk for unplanned pregnancies and sexually transmitted diseases. In addition, secondary schools require that pregnant students drop out of school, thus limiting opportunities for future employment. When this study was conducted, the rule suspending pregnant students for one year also applied to teacher training and other professional colleges, regardless of the age or marital status of the student. The rule has now been rescinded for these institutions

The purposes of this study were 1) to determine patterns of sexual activity, contraceptive use, and pregnancy experience among young Zimbabwean women, 2) to compare the academic and vocational goals of sexually inactive students, sexually active students who have never been pregnant, and

students who left school because of pregnancy, and 3) to identify relationships between young women's sense of personal control in their lives and pregnancy prevention<sup>88</sup>

The study began with three focus group discussions — one with college students and two with school dropouts. These discussions became the basis for a survey that was designed and administered to 970 female students at three teacher training colleges: Morgenster (located in Masvingo province), a rural mission college, and Belvedere (in Harare) and Marymount (in Mutare), government institutions in urban areas. Belvedere and Marymount provide contraceptive services for students, while Morgenster does not

In addition to the survey, in-depth interviews were held with 15 women under age 25 who had recently given birth and left school as a result of pregnancy. Interviews also were held with 20 "community mothers," women ages 18 to 25, who



*"It was my first time to have sex and it [pregnancy] just happened that day. I did not know that I could become pregnant at my first encounter."*

**Zimbabwean woman**

had been out of school for at least two years, and with six women from each of the three colleges who had returned to school after pregnancy

Analysis of data revealed that 32 percent of the college students surveyed were married, and 14 percent were divorced or widowed. Fifty nine percent were sexually active, with 5 percent reporting first intercourse as early as primary or secondary school. Twenty seven of those surveyed (1 percent) said they had had at least one pregnancy while in primary or secondary school. Thirty five (4 percent) had been pregnant in college. These numbers probably under represent the adolescent pregnancy rates in the general population, since they reflect the experience of students who have continued their education.

Nearly two thirds of the women said they did not use a contraceptive the first time they had intercourse. For women who did use contraceptives condoms were the most popular choice, yet over time, women switched to the pill. "Pills are available and the community health worker brings them nearer to our homes. You don't have to travel the whole way to the clinic," said one woman. Another noted that condoms could be a problem, since they are controlled by a partner and not the woman herself. "Men do not like condoms," said one woman who returned to school after pregnancy. "You might want to use [them], but if he does not want to, he will refuse. In the first place, he has to look for a condom himself. You will never know, you might even become pregnant with these condoms as the man is the one who controls it."

Among sexually active students, 83 percent said they used a contraceptive method during most or all of their recent sexual encounters. However, among the community mothers, women were more likely to want more children and thus to view contraception as an option after they reached desired family size.

College students are able to obtain contraception at public, private or school clinics or at pharmacies. But as secondary pupils, they were discouraged by family planning clinics from using contraception and had to rely on mothers, sisters or other individuals for information. "When I was still at school, there was nowhere I could get pills or anything to [prevent] pregnancy,"

said one woman who dropped out of school following pregnancy. Said another, "I used to get pills from a woman who sold them to us as girls privately in Mbare. We had to keep it a secret that she sold pills to us. We were afraid parents would be very angry if ever they knew we were involved in such a scandal."

A community mother, who had been expelled from school when she became pregnant, explained her unsuccessful attempts to get contraception. "My boyfriend had waited so long, he wanted and I also wanted to experience how it [sex] feels. I had tried to get some tablets, but I was chased from the clinic. I think it was because I looked very young at the time. I also tried to ask my big sister to help me, but instead she discouraged me, saying tablets were not good, as they would make me barren in the future. But now I regret it. I could have finished school. Maybe I could have been a teacher like him [my husband], because now when I ask for money, he tells me that he went to school alone."

Not only did the women who were sexually active before college have difficulty getting contraception, they had very little knowledge about the methods they used. Among women whose first sexual experience had been in primary or secondary school, 74 percent said they knew nothing about contraception at the time. "It was my first time to have sex and it [pregnancy] just happened that day. I did not know that I could become pregnant at my first encounter," said one woman.

Most of the students, sexually active or not, held high academic aspirations. This was true for many of the community mothers, who expressed regret that they were financially unable to return to school after pregnancy. "If I had [had] access to the method of preventing pregnancy I wouldn't have been pregnant and I would have finished my O levels," said one woman. "and you never know, I might have passed. And I would be working somewhere in town, and maybe I would be having a better life than this one." Another woman said, "I wish I could go back to school. You know, I have four subjects [at the] O level, and I only need one to have a complete certificate. But my husband can't afford it, and I have a family to look after."

## The Mediating Effects of Gender on Women's Participation in Development

The purpose of this qualitative study was to identify negative and positive gender influences and the extent to which they affect women's autonomy in household decisions (including family planning decisions) and women's participation in economic, political and other community activities.<sup>99</sup> Researchers at the Institute for Development Studies, University of Zimbabwe, interviewed 40 women, ages 25 to 40 with five or more children, and 40 women with four or fewer children. They also interviewed married men and older women to understand better the social context in which younger women make decisions.

Analysis of the data from interviews with high and low fertility women was incomplete at the time this report was published. Therefore, findings are presented only from interviews and focus groups with married men and with older women who have daughters in law.

Mothers in law said they encouraged family planning but saw contraceptive use as a means of limiting pregnancies after a woman had attained her desired family size. A large family was necessary to extend the family line, they said. "It is better for one with six children to use family planning because she already has a large family," said one urban woman. Another woman said, "In our culture, we expect the new couple to have children before spacing." Nevertheless, mothers in law recognized the economic difficulties in supporting a large family. "Those with small families find it easy to send their children to school," said one woman. "There are rare cases where parents manage to educate a large family."

Mothers in law felt comfortable advising their daughters in law about schooling for children, and they encouraged daughters in law to return to school, perceiving that education would lead to new employment opportunities and improved economic benefits for the family. Some said they would tend grandchildren if the mother returned to school. While older women supported the idea of additional family income, they also worried that work outside the home would diminish women's interest in their families. "Some

forget about their husband's family once they work, or even their own families. Some get into extramarital affairs," said one mother in law. "I support her [work]," said one woman, "but I always advise her to work well and know her priorities. She should remember she has a family." Another said, "Some get boyfriends and buy expensive perfumes and lotions, forgetting families."

Older women supported women's participation in political clubs and organizations, believing women could best represent the interests of other women and that such participation would improve women's status. "If she gets into a political position, she will help other women's problems because she knows them," one woman said. Another said, "[We] are still behind, but if we support each other, it might work."

While mothers in law offered advice, men saw themselves as the ultimate authority in the home. Many men felt their responsibility as financial providers entitled them to have the final word in decisions about family size. "It is the husband (who makes decisions), because he is the one who feels the burden of supporting the family," said one rural man. "A wife is like a box that I purchased because I paid for her," said an urban husband.

Men supported family planning, and said they were typically the ones who initiated discussions about family size and contraception. "We discuss family planning," said a rural father with one child. "We talk about how we should space our children and which family planning method to use." Another man from rural Chivi said, "Personally I like the idea of using [a] family planning method, because when I grew up we were so many in our family, and that is partly why I could not further my education. So if you have one or two children who are well spaced, you can at least manage to educate them."

Some husbands acknowledged that couples might sometimes use family planning before they had reached desired family size. "Even when you have two children you can use family planning as much as someone with many children," said one urban father with four children. "More often, family planning methods are used to maintain the health of the mother by spacing the births well

Your wife may grow thin, and if she uses family planning, she might recover” Men also felt family planning could improve a couple’s sexual relationship “It gives us enough time to enjoy our wives, especially when it comes to sex,” one man said But other men said that contraceptive use should begin only after fertility had been proven One man said, “No, we are a new family, and I need a child So we have not discussed using family planning methods” Another said, “If a newlywed takes three to four years to conceive, in laws wonder whether the child belongs to their son or to someone else”

Men supported their wives’ education as a means to improve family income “We know that the earnings they acquire will trickle down to us,” said one husband Although most men approved of women bringing income into the home, they emphasized that women’s domestic responsibilities should remain their top priority “Suppose she does take that course She could then say, ‘I am tired, you should cook today’ That is why some men do not want their wives to further their education” Men’s ambivalence was also reflected in their fear that women working outside the home would become promiscuous

Men acknowledged that their wives vote, and that some women participate in political organizations However, rural and urban men differed sharply in their approval of women’s participation in political activities “A married woman should stay out of politics because she will be difficult to control,” said an urban man “They also bring AIDS because they travel a lot” Conversely, rural men thought women would do well in politics “Some women are more intelligent than men and should be given the chance to lead people,” said one

Although data on women’s participation in household and development activities were not available at the time of this report, results of interviews with men and older women suggest that

gender norms probably have strong influence on women’s participation in development These norms affect whether women with smaller families are able to experience greater mobility and gender equity as a consequence of family planning and lower fertility

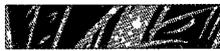
### Consequences of Family Planning on the Quality of Women’s Lives

This qualitative study explored women’s perceptions of quality of life<sup>100</sup> Women were asked how they would define quality of life, how family planning use/non use affect quality of life, if and how quality of life is related to women’s status, including their autonomy in household decision making, use of time, employment, and involvement in political or civic activities, and what strategies women use for coping with negative consequences of contraceptive use

More than 130 women and men, ages 18 to 40 living in the Mashonaland East province, participated in 16 focus group discussions Thirteen focus group discussions were held for women, and three for men

Study participants generally defined quality of life as satisfaction with one’s life and one’s identity, having dreams that are realistic, and hopes and aspirations based on the reality of one’s circumstances However, transcripts show that study participants’ definition of quality of life is multifaceted As study participants grappled with the meaning of the concept in their own lives, their discussions indicated that quality of life has physical, social, cultural, and spiritual dimensions

Both women and men said quality of life means mutual respect and domestic harmony Women emphasized marital contentment arising from satisfaction with one’s livelihood and the couple’s ability to plan and provide for children, as well as having a husband who is a good breadwinner for the family Women placed high value on having the time and ability to raise and nurture their families



*“ I tell her [my daughter-in-law] to have six children, but she will say it is impossible, but four will do She says six children are a burden She also says pregnancies are painful ”*

**Mother in law in Zimbabwe**

Men tended to concur, defining quality of life for women in terms of the woman's responsibility to maintain the home. Men called women, 'pillars of the home,' and described their role as the most difficult one in the family. Factors that, in men's view, contribute to a family's quality of life include a wife who is well looked after by her husband, who maintains a well kept home, and who can show that she and her family are in good health. However, some men complained that women's attitudes are changing, and spoke negatively of women who value making money over raising their children. Others said women incorrectly perceive themselves as subservient to men. In general, men expressed empathy and respect for women's roles in childbearing, maintaining the household and obtaining contraception.

Both women and men said that planning a family — the number of children the couple wants and can support — is an important element of quality of life. There is nothing to be gained, they said, from not using family planning and advised that more methods should be available and price subsidies should be offered to help couples afford contraception.

Men said women should take the lead in discussing family size and family planning, since they are the ones responsible for childrearing. In reproductive decisions, women said they take into account the economic as well as physical consequences of childbearing, stretching limited resources to make contraception part of the household budget.

Women said a benefit of family planning is improved health for the mother and the entire family, more time for rest and leisure, and the ability to devote adequate time and affection to children and husbands. According to men, the benefits of contraceptive use are reaped by the entire family. By limiting births, men can adequately provide for their families, women can protect their physical and mental health, and the couple can enjoy

more time together. "Having 10 to 11 children may be so detrimental to the psychological well being of a wife that she feels she is being used as a human making machine," said one husband.

Women identified several negative consequences of family planning use, including method failure, prolonged menstrual bleeding and headaches. Women's strategies for improving the quality of their experiences with family planning were seeking more information on contraceptive use, including education from other women, ignoring in laws' comments, visiting a doctor before initiating contraception, and receiving family planning counseling with their husbands. Women said they wanted health providers to be more attentive to their concerns and to listen to their suggestions for improving family planning programs including the need of many families for price subsidies. Men said they wanted women to share problems with them but stressed that confidentiality about contraceptive use is important.

Women and men also discussed quality in different domains of their lives.

**Home** Women described themselves as heads of the household (in relation to the family's daily needs) and men as "executive heads of the homestead." Men too, defined women as heads of the home and said women should supervise the family budget, perform all the household chores, and care for the husband and children. They also said that before making decisions, a woman should seek concurrence from her spouse.

**Work** Women said that working for pay provides the economic means to pursue physical health and mental and spiritual well being. They also saw work as an activity that could increase their visibility in the community and, consequently, their credibility when voicing opinions on women's issues. Men voiced support of equal job opportunities for women but added that women's unpaid work, such as caring for the family, promotes cohesion in the community.



*" Having 10 to 11 children may be so detrimental to the psychological well-being of a wife that she may feel she is being used as a human-making machine "*

**Man in Mashonaland East province Zimbabwe**

**Community** Women said that they would like to participate in political activities to promote positive change in their country and enhance quality of life, but they found little time for such activities. Men said they felt motivated to participate in political activities to improve quality of life for women.

**Education** Women linked education with contraception, saying that a child's education begins with family planning — if children are planned, parents can better afford school fees. Women said children should receive an education, irrespective of gender, and that education promotes women's self development, opens new opportunities for employment, and helps women develop skills for family planning and household budgeting. Men supported women's education, saying that it can help women learn how best to manage the household budget and communicate with spouses. Men rejected the tradition that only males should inherit property, saying this practice ultimately has a negative impact on women's quality of life.

Analysis of data from this study illustrates the overriding importance of practical versus strategic gender issues in the social definition of quality of life. For both sexes, mutual respect and household harmony are principal components of the concept. Key to attaining a positive quality of life are the traditional divisions of labor in the household and the roles of women as wives and mothers. Education for women was associated with quality of life but to help them fulfill their traditional role as homemakers, not to promote gender equality in the community. Although investigators recommend further analysis, there is little data thus far to suggest that women associate greater autonomy, mobility outside the home and relief from domestic burdens with efforts to meet women's strategic need for gender equity. Men do emphasize "teamwork" however, and women say they value employment as a means to achieve greater credibility when speaking out on women's issues. These findings hint at the possibility of a social transition.

# APPENDIX 1

## THE WOMEN'S STUDIES PROJECT

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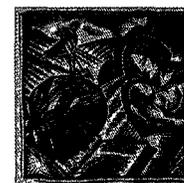
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## APPENDIX 2

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# APPENDIX 3

## WOMEN'S STUDIES PROJECT

### PUBLICATIONS AND PRESENTATIONS



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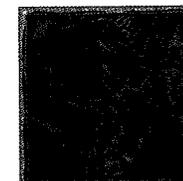
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## APPENDIX 4 WSP Subprojects Descriptions and Methods

Title	Location	Agency	Dates	Methods		Sample		
				Qualitative	Quantitative	Men	Women	Men and Women
<b>ASIA</b>								
<b>Bangladesh</b>								
Social Transformation in Bangladesh: Secondary Analysis of Data on Family Planning and Women's Changing Roles and Status: Part I	Rangpur and Magura districts (rural)	<ul style="list-style-type: none"> <li>John Snow Inc</li> <li>Training Institute and Development Research Centre (Dhaka)</li> </ul>	Sep 1994 Feb 1995	Secondary analysis of ethnographic data		139	151	Most of the men and women were couples
Social Transformation in Bangladesh: An Ethnographic Study of Family Planning and Women's Roles and Status: Part II	Rangpur and Magura districts (rural)	<ul style="list-style-type: none"> <li>John Snow Inc</li> <li>Training Institute and Development Research Centre (Dhaka)</li> </ul>	Feb Sep 1995	Secondary analysis of ethnographic data		<ul style="list-style-type: none"> <li>139</li> <li>Key informants</li> </ul>	151 Key informants	Most of the men and women were couples
<b>China</b>								
Impact of Family Planning on Women's Lives	South Jiangsu and North Anhui provinces	China Population Information and Research Center	Jan 1996 Dec 1997	FGDs	Survey: random sample	<ul style="list-style-type: none"> <li>Survey: 506</li> <li>FGDs: 56 with 155 men (older reproductive age, unmarried)</li> </ul>	Survey: 1,996	<ul style="list-style-type: none"> <li>FGDs: 56 with 220 women (older reproductive age, unmarried entrepreneurs)</li> </ul>
<b>Indonesia</b>								
Women's Reproductive Decision Making and Its Relation to Psychological Well-being	South Sumatra and Lampung	<ul style="list-style-type: none"> <li>Center for Societal Development Studies: Atma Jaya Catholic University</li> <li>Women's Studies Program: University of Indonesia</li> </ul>	Feb 1996 Sep 1997	<ul style="list-style-type: none"> <li>FGDs: In-depth interviews</li> </ul>	Survey	FGDs: 4 with 32 men	<ul style="list-style-type: none"> <li>FGDs: 8 with 78 women</li> <li>Survey: 796 (ages 30-45, ever married, at least 1 child)</li> <li>Interviews: 24</li> </ul>	

FGDs — Focus Group Discussions



## APPENDIX 4 WSP Subprojects Descriptions and Methods — continued

Title	Location	Agency	Dates	Methods		Men	Sample	
				Qualitative	Quantitative		Women	Men and Women
Impact of Family Planning on Women's Empowerment in the Family	Jakarta and Ujung Pandang	Kelompok Studi Wanita (Women's Study Center) University of Indonesia	Feb 1996 Dec 1997	In depth interviews with sub sample	Survey		Survey 768 (ages 30-45 married)	30 couples interviewed separately
Impact of Family Planning on Women's Economic Activity and Household Autonomy	Quantitative national • Qualitative North Sumatra West Java	Demographic Institute University of Indonesia	Feb 1996 Sep 1997	In depth interviews	Secondary analysis of 1993 Indonesia Family Life Survey	Interviews 2 male community leaders	<ul style="list-style-type: none"> <li>• Secondary analysis 4 617 (ages 15-49 married)</li> <li>• Interviews 2 female community leaders</li> </ul>	16 couples interviewed separately
Impact of Contraceptive Use and Fertility on Family Welfare and Women's Activities	Central and East Java	Population Studies Center Gadjah Mada University	Feb 1996 Sep 1997	In depth interviews	Survey random sample	<ul style="list-style-type: none"> <li>• Survey 931 (ages 15-49 married)</li> <li>Interviews 16 (sub sample)</li> </ul>		
<b>Republic of Korea</b>								
Changes in Patterns of Work Life and Reproductive Behavior	Seoul	Korea Institute for Health and Social Affairs	Sep 1997 Feb 1998	FGDs	Secondary analysis of annual national economic and social statistics		Annual national surveys	
Impact of the Fertility Transition on Women's Participation in Political Activity	Seoul	Institute for Social Development and Research Seoul National University	Sep 1997 Feb 1998	FGDs			FGDs 1 with older upper class women 1 with younger women (repeated)	
Impact of the Fertility Transition on Domestic Roles and Family Relationships	Seoul	<ul style="list-style-type: none"> <li>• Ewha Women's University</li> <li>• Korean Women's Development Institute</li> </ul>	Sep 1997 Feb 1998	FGDs			FGDs with middle and low income participants	

**APPENDIX 4 WSP Subprojects Descriptions and Methods — continued**

Title	Location	Agency	Dates	Qualitative	Methods		Sample	
					Quantitative	Men	Women	Men and Women
Impact of the Fertility Transition on Women's Self esteem and Self Concept	Seoul	Ewha Women's University	Sep 1997 Feb 1998	FGDs			FGDs 3 groups with older middle aged and younger women	
<b>Malaysia</b>								
Family Planning and Women's Lives	National	Population and Development Program Cornell University	Jan 1995 Sep 1995		• Secondary analysis of data from Malaysia Family Life Survey (MFLS I & II) Interviews with women from MFLS II		• 889 women interviewed in 1977-1988 • 1 867 women interviewed in 1988-1995	
<b>Philippines</b>								
Cebu Longitudinal Study Secondary Analysis	Cebu	• Carolina Population Center University of North Carolina • Office of Population Studies at University of San Carlos Cebu	Mar 1994 May 1996		Secondary analysis of 1983 Cebu Longitudinal Health and Nutrition Survey and 1991 follow up surveys		2 395 women in baseline and follow up	
Cebu Longitudinal Follow Up Study	Metropolitan Cebu (rural and urban communities)	• Carolina Population Center University of North Carolina • Office of Population Studies at University of San Carlos Cebu	Mar 1994 Sep 1997	• 3 pre survey FGDs • 3 in depth interviews	Survey follow up to 1983-1991 Cebu Longitudinal Health and Nutrition Survey		Survey 2 279 (ages 15-55) + additional 500 (ages 15-25) • Interviews 60 (subgroup of survey)	
Economic and Psychosocial Influence of Family Planning on the Lives of Women in Western Visayas	Iloilo City Island of Pinay	Social Science Research Institute Central Philippines University	Oct 1995 Mar 1998	• FGDs (9 pre survey 27 post survey) • In depth interviews	Survey with stratified sample of agricultural coastal and urban communities		Survey 1 100 (ages 15-49 married) • FGDs 36 mixed groups • Interviews 50 key informants	
Social and Economic Consequences of Family Planning Use in the Southern Philippines	Cagayan de Oro City Northern Mindanao Bukidnon Province	Research Institute for Mindanao Culture (RIMCU) Xavier University	Oct 1995 Mar 1998	FGDs	Survey with cluster samples (urban-rural rural included less developed and tribal communities)		• Rural survey 650 from 1994 UNICEF survey (ages 15-49 married) • Urban survey 1 000 (ages 15-49 married)	FGDs 6 mixed groups

FGDs — Focus Group Discussions

## APPENDIX 4 WSP Subprojects Descriptions and Methods — continued

Title	Location	Agency	Dates	Methods		Sample		
				Qualitative	Quantitative	Men	Women	Men and Women
<b>LATIN AMERICA AND THE CARIBBEAN</b>								
Bolivia								
Psychosocial Impact of Fertility Regulation on Women	El Alto	Proyecto Integral de Salud	Dec 1995 Feb 1998	In depth interviews/ life histories		31 men	3 groups 36 modern method users 33 discontinuers 32 non users	
Impact of Men's Knowledge Attitudes and Behavior Regarding Fertility Regulation on Women's Lives	Cochabamba (urban)	Cooperazione Internazionale	Nov 1995 May 1998	8 FGDs to help develop psychosocial indicators	Structured interviews with multistage probability sample			630 couples (women ages 20-49)
Access to and Use of Reproductive Health Service	El Alto	PRO MUJER	Jan 1995 May 1997	18 FGDs	<ul style="list-style-type: none"> <li>• Situation analysis of 45 health facilities and 35 pharmacies</li> <li>• In depth interviews</li> </ul>	<ul style="list-style-type: none"> <li>• FGDs 9 groups</li> <li>• Interviews 55</li> </ul>	<ul style="list-style-type: none"> <li>• FGDs 9 groups</li> <li>• Interviews 55</li> </ul>	
Women's Participation in the Work Force Follow Up of 1994 Demographic and Health Survey	<ul style="list-style-type: none"> <li>• El Alto</li> <li>• La Paz</li> </ul>	Consultants Mario Gutierrez and Teresa Polo	Mar 1997 Apr 1998		Longitudinal Demographic and Health Survey follow up by interviews		816 women who participated in 1994 Demographic and Health Survey	
Case Study of Two Reproductive Health Programs	<ul style="list-style-type: none"> <li>• El Alto</li> <li>• Santa Cruz</li> </ul>	Susan Paulson Maria Elena Gisbert Mery Quiton	Nov 1995 Oct 1996	Case studies of 2 women centered reproductive health programs				
Gender Guidelines and Training Project	<ul style="list-style-type: none"> <li>• El Alto</li> <li>• La Paz</li> </ul>	Centro de Informacion y Desarrollo de la Mujer (CIDEM)	Feb 1998 Aug 1998	Development of training guidelines				

**APPENDIX 4 WSP Subprojects Descriptions and Methods — continued**

Title	Location	Agency	Dates	Methods		Sample		
				Qualitative	Quantitative	Men	Women	Men and Women
<b>Brazil</b>								
Adolescent Longitudinal Study: Social and Behavioral Consequences of Pregnancy among Young Adults in Fortaleza Ceará	Fortaleza	Maternidade Escola Assis Chateaubriand (MEAC)	Sep 1995 Aug 1998		Structured interviews (longitudinal) with pregnant girls and with girls who had abortions (will also look at 1 year child outcomes)		<ul style="list-style-type: none"> <li>• 367 adolescent mothers (ages 12-18)</li> <li>• 196 teens who aborted</li> </ul>	
Comparative Study of the Impact of Female Sterilization on Women's Lives	Campinas	Centro de Pesquisas das Doenças Materno-Infantis de Campinas (CEMICAMP)	Dec 1996 Jun 1997	FGDs to develop psychosocial measures	Two stage probability sample structured interview with open ended questions at least 5 years after sterilization		<ul style="list-style-type: none"> <li>• 236 with tubal ligation (ages 30-49)</li> <li>• 236 without tubal ligation (matched on age community)</li> </ul>	
<b>Jamaica</b>								
The Jamaica Adolescent Study	5 parishes (rural and urban)	Fertility Management Unit University of the West Indies	Apr 1995 Jun 1998	FGDs	Interviewer administered questionnaire to group at 3 points in time	<ul style="list-style-type: none"> <li>• Survey 463 boys</li> <li>• FGDs 8 groups 32 participants (1996)</li> <li>• FGDs 8 groups 32 participants (1997)</li> </ul>	<ul style="list-style-type: none"> <li>• Survey 482 girls</li> <li>• FGDs 8 groups 32 participants (in 1996 and again in 1997)</li> </ul>	
Case Study of Women's Center of Jamaica Foundation Program for Adolescent Mothers	Kingston	Fertility Management Unit University of the West Indies	Sep 1995 Jun 1997	Case study FGDs with former program participants interviews with current participants and community members				

FGDs — Focus Group Discussions

## APPENDIX 4 WSP Subprojects Descriptions and Methods — continued

Title	Location	Agency	Dates	Methods		Men	Sample	
				Qualitative	Quantitative		Women	Men and Women
<b>AFRICA AND THE MIDDLE EAST</b>								
<b>Egypt</b>								
Impact on Family Planning on Lives of Egyptian Women	Lower and Upper Egypt (rural and urban)	Social Research Center American University in Cairo	Apr 1996 Jul 1998	<ul style="list-style-type: none"> <li>• FGDs</li> <li>• In depth interviews</li> </ul>	Cross sectional survey with sample drawn from women who participated previously (1991-1993) in a national study		<ul style="list-style-type: none"> <li>• FGDs 12 groups ever married women</li> <li>• Survey 1 327 women who had unplanned pregnancies</li> </ul>	
Role of Women as Family Planning Employees in Egypt	National	Cairo Demographic Center	Jan 1996 Aug 1997	<ul style="list-style-type: none"> <li>• FGDs</li> <li>• In depth interviews</li> </ul>	Secondary data from 6 largest family planning service organizations		<ul style="list-style-type: none"> <li>• Employment records n=19 018 (82% female)</li> <li>• FGDs 64 groups</li> </ul>	Interviews 19 managers/directors of programs
Family Planning Among Adolescent Married Women in Squatter Areas of Alexandria	Alexandria	High Institute of Public Health Alexandria University	1998	FGDs	Interview cluster sample	FGDs 2 groups	FGDs 2 groups	<ul style="list-style-type: none"> <li>• 450 married couples where woman is not adolescent</li> <li>• 450 married couples where woman is adolescent</li> </ul>
Knowledge Attitudes and Behavior Study about Reproductive Health among Adolescents and Youth in Assiut Upper Egypt	Upper Egypt	Faculty of Medicine Assiut University	1998	4 FGDs of 10 to aid in instrument development	Survey of 3 600 men women married unmarried between ages 15-24 cluster sample			
Family Planning Use and Offspring Gender Equity	Alexandria	Faculty of Nursing Alexandria University	1998	FGDs to develop questionnaire	Survey of users of health facilities		<ul style="list-style-type: none"> <li>• Survey 700 1/2 with &lt;= 3 children</li> <li>• 1/2 with &gt;3 children</li> <li>• FGDs 60 women</li> </ul>	

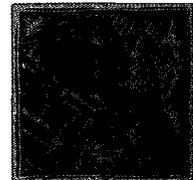
## APPENDIX 4 WSP Subprojects Descriptions and Methods — continued

Title	Location	Agency	Dates	Methods		Sample		
				Qualitative	Quantitative	Men	Women	Men and Women
Social and Behavioral Outcomes of Unintended Pregnancy	National	Cairo Demographic Center	1998	In depth interviews	Analysis of statistical data from 2 surveys (1993 and 1997)		Interviews 20 Survey 1 700 women	
<b>Mali</b>								
Impact of Family Planning Use on the Lives of New Contraceptive Users in Bamako	Bamako	Centre d Etudes et de Recherche sur la Population pour le Developpement (CERPOD)	1996 1998	<ul style="list-style-type: none"> <li>In depth interviews new users 3 times in 18 months never users 2 times in 5 months</li> <li>FGDs</li> </ul>		FGDs 3 groups of husbands	<ul style="list-style-type: none"> <li>Interviews 50 new users (ages 18 45 married) 32 never users (ages 18 45 married)</li> <li>FGDs 3 groups mothers in law 3 groups experienced users</li> </ul>	
<b>Zimbabwe</b>								
Impact of Family Planning on Women's Participation in the Development Process	National	Center for Population Studies University of Zimbabwe	1997	Some qualitative data in survey	<ul style="list-style-type: none"> <li>Secondary analysis of Demographic and Health Survey (1988 1994) and Reproductive Health Survey (1984)</li> <li>Survey</li> </ul>		Survey 2 465 (ages 15 49)	
Impact of Family Planning on Academic Achievement and Vocational Goals of Young Women	<ul style="list-style-type: none"> <li>Masvingo</li> <li>Harare</li> <li>Mutare</li> </ul>	Department of Sociology University of Zimbabwe	1997	<ul style="list-style-type: none"> <li>FGDs to help design survey</li> <li>In depth interviews</li> </ul>	Survey		<ul style="list-style-type: none"> <li>Survey 1 200 teachers college students</li> <li>Interviews 15 post partum dropouts (age &lt;25) 18 formerly pregnant students 20 other mother dropouts</li> </ul>	
Mediating Effects of Attitudes of Significant Others on Women's Participation in Development	Masvingo province	Institute for Development Studies University of Zimbabwe	1997	<ul style="list-style-type: none"> <li>In depth interviews</li> <li>FGDs</li> </ul>		Interviews 22 married men (ages 25 50)	Interviews 44 women (ages 25 40 married) 33 women (ages 40+ married)	FGDs 16 groups of men and women
Consequences of Family Planning on Women's Quality of Life	Mashonaland East province	Department of Psychiatry University of Zimbabwe	1997	FGDs		3 groups	13 groups (ages 18 40)	

FGDs — Focus Group Discussions

**APPENDIX 5 WSP Subprojects Model Categories and Findings**

Title	Gender Norms	Life Stage Personal Factors	Family Planning Programs	Contraceptive Use/ Non use	Pregnancies/Child bearing	Psychological/Physical Well being	Household/ Family Roles	Societal/ Economic Roles	Findings
<b>ASIA</b>									
<b>Bangladesh</b>									
Social Transformation in Bangladesh Secondary Analysis of Data on Family Planning and Women's Changing Roles and Status Part I	X		X	X	X	X	X		<ul style="list-style-type: none"> <li>• Home based services have increased use of family planning in rural areas</li> <li>• Home based delivery is geared to women this approach may unintentionally have the effect of reinforcing gender norms including isolation subordination and economic dependency</li> <li>• Home based services can offer only a limited choice of methods (mainly pills and condoms) compared with clinic based services</li> <li>• Some women afraid to use family planning because of health risks</li> <li>• Side effects not always treated by providers</li> </ul>
Social Transformation in Bangladesh An Ethnographic Study of Family Planning and Women's Roles and Status Part II	X		X	X		X	X		<ul style="list-style-type: none"> <li>• Family planning ideology has been internalized by Bangladesh women Some wish they had used family planning earlier or more effectively</li> <li>• Women can take the initiative in family planning but that does not empower women in other spheres</li> <li>• Perceived benefits include economic health and physical well being happiness and harmony in the home</li> <li>• Women suffered greater social ostracism in past for family planning use</li> <li>• Spouse conflict can result with women sometimes at risk</li> <li>• Perceived negative expectations include side effects criticism and for a few regret over abortion and sterilization 42% experienced side effects</li> </ul>
<b>China</b>									
Impact of Family Planning on Women's Lives	X	X	X	X	X	X	X	X	<ul style="list-style-type: none"> <li>• 66% of respondents said family planning positively related to women's health household work education economic activities and leisure</li> <li>• Use at 90% use IUDs after first child sterilization after second</li> <li>• Family planning is women's responsibility</li> <li>• 10 25% had abortions high failure rate of steel ring IUDs</li> <li>• Gender and generational roles changing slowly Women working for income but still responsible for household work</li> <li>• Information and services not available for unmarried women</li> <li>• Strong son preference prevails</li> </ul>



**APPENDIX 5 WSP Subprojects Model Categories and Findings — continued**

Title	Gender Norms	Life Stage Personal Factors	Family Planning Programs	Contraceptive Use/ Non use	Pregnancies/Child bearing	Psychological/Physical Well being	Household/ Family Roles	Societal/ Economic Roles	Findings
<b>Indonesia</b>									
Women's Reproductive Decision making and its Relation to Psychological Well being	X	X	X	X	X	X	X	X	<ul style="list-style-type: none"> <li>• Women responsible for choosing method men for deciding how many children</li> <li>• Users felt more control over reproductive lives and more satisfied with relationships with others</li> <li>• Users generally satisfied with family planning but much method change due to side effects</li> <li>• Users did not feel they received enough information from providers</li> <li>• Use was not related to time domestic responsibilities including child care opportunity stress vitality family welfare</li> <li>• Qualitative data indicate problems related to side effects of contraceptive use and with husbands support for contraceptive use</li> </ul>
Impact of Family Planning on Women's Empowerment in the Family	X	X	X	X	X		X	X	<ul style="list-style-type: none"> <li>• Except for side effects women did not report negative results from family planning use</li> <li>• Some relationships between economic and social autonomy and family planning use</li> <li>• Most women did not work younger women using family planning more likely to work</li> <li>• Qualitative data showed men more dominant in households than did quantitative data women generally make decisions about daily expenses men make decisions on larger expenditures</li> </ul>
Impact of Family Planning on Women's Economic Activity and Household Autonomy	X	X	X	X	X		X	X	<ul style="list-style-type: none"> <li>• Family planning only partly explained women's work status</li> <li>• Education key determinant of work status</li> <li>• Women worked for income and to help husbands with family economy</li> <li>• Neither women's household role nor autonomy were related to family planning use or work status</li> <li>• Autonomy in one domain not necessarily related to autonomy in another</li> <li>• Family planning and work helped meet household and family needs</li> </ul>
Impact of Contraceptive Use and Fertility on Family Welfare and Women's Activities	X	X	X	X	X		X	X	<ul style="list-style-type: none"> <li>• Family planning and fertility had only a modest effect on women's social and economic activities and on family welfare</li> <li>• Small families and use of family planning the norm</li> <li>• Household and economic burdens considered more salient to family welfare</li> <li>• Women not enthusiastic about working</li> <li>• Many women affected by contraceptive side effects</li> </ul>

**APPENDIX 5 WSP Subprojects Model Categories and Findings — continued**

Title	Gender Norms	Life Stage Personal Factors	Family Planning Programs	Contraceptive Use/ Non use	Pregnancies/Child bearing	Psychological/Physical Well being	Household/ Family Roles	Societal/ Economic Roles	Findings
<b>Republic of Korea</b>									
Changes in Patterns of Work Life and Reproductive Behavior		X			X		X	X	<ul style="list-style-type: none"> <li>• Fertility decline preceded an increase in married women's labor force participation</li> <li>• Compared with earlier generations' women marry later have a small number of children quickly and become free from child care in their early 30s</li> <li>• Both older and younger women quit work upon marriage or first birth except if they had very good jobs</li> <li>• Women adjust reproductive behavior to work life and vice versa</li> </ul>
Women's Self esteem and Power	X	X				X	X	X	<ul style="list-style-type: none"> <li>• Regardless of work or employment women had strong family orientations</li> <li>• Younger women did not quit work when they married unlike older women</li> <li>• Older women developed autonomous selves gradually through performing conventional gender roles</li> <li>• Younger women did the same but through a different means more liberal socialization and higher education</li> <li>• Older women had higher self esteem than younger women</li> <li>• Work outside the home had both positive and negative impacts on empowerment and self esteem independent income was a plus but not having time to perform traditional roles was a minus</li> </ul>
Changing Gender Roles and Gender Identity in Korea	X	X				X	X	X	<ul style="list-style-type: none"> <li>• All women in the study were exposed to gender stereotypic socialization</li> <li>• Younger women experienced a more flexible socialization process</li> <li>• Unexpectedly older women had a stronger masculine gender identity</li> <li>• Younger women were more likely to share roles with husbands</li> <li>• Research is needed on the ongoing process of gender socialization later in life</li> </ul>
Influence of Fertility on Women's Division of Labor and Family Relations		X	X	X	X				<ul style="list-style-type: none"> <li>• Adoption of small family norm and use of family planning shortened cycle for childrearing</li> <li>• The government family planning program was targeted to women and may have contributed to deterioration of women's health</li> </ul>
Childrearing Roles and Self Identity A Comparison of Women in their 30s and 50s	X					X	X	X	<ul style="list-style-type: none"> <li>• Women are caught between an employment system that asks for a commitment to work a childrearing system that defines women as primary caregivers a shortage of child care facilities and traditional male attitudes</li> <li>• As society changes the kind of child that is successful may also change Traditionally Korean childrearing encouraged the mother's sacrifice and the child's dependency rather than independence and creativity</li> <li>• Changes toward a more egotistical orientation may contribute to family instability conflict and marginalization of the husband</li> </ul>

### APPENDIX 5 WSP Subprojects Model Categories and Findings — continued

Title	Gender Norms	Life Stage Personal Factors	Family Planning Programs	Contraceptive Use/Non use	Pregnancies/Child bearing	Psychological/Physical Well being	Household/Family Roles	Societal/Economic Roles	Findings
Changing Perceptions of Gender Relations: A Resource for Mobilizing Women	X	X						X	<ul style="list-style-type: none"> <li>• Despite educational gains and fertility decline, Korean women have low participation in formal political institutions (but more in social movements)</li> <li>• Younger women in particular have become increasingly critical of existing gender relations while older women are more fatalistic</li> </ul>
Attitudes toward Political Participation among Korean Women	X						X	X	<ul style="list-style-type: none"> <li>• Neither older nor younger women were interested in politics either as observers or participants</li> <li>• Both were disappointed in present politicians and the political climate</li> <li>• When the focus group with younger women was repeated (after the economic crisis) they were shocked to see how their day to day lives were affected by political decisions and the presidential election</li> </ul>
<b>Malaysia</b>									
Family Planning and Women's Lives		X		X			X	X	<ul style="list-style-type: none"> <li>• Users less likely to experience marital disruption, effect stronger if used early in marriage</li> <li>• Modern method use not related to marital disruption</li> <li>• Use not related to entry or exit from labor force, but few women worked outside of home</li> </ul>
<b>Philippines</b>									
Cebu Longitudinal Study: Secondary Analysis		X		X	X	X	X	X	<ul style="list-style-type: none"> <li>• High fertility associated with age, lower education, lower income, rural residency, poor diet</li> <li>• Labor force participation jumped from approximately 50% (1983) to nearly 75% (1991)</li> <li>• Women with children younger than 2 years old less likely to be working</li> <li>• Increased earnings due to increase in hours and wages</li> <li>• Women in formal sector more likely to have increase in wages, women in informal sector more likely to have increase in hours</li> <li>• Additional children negatively related to maternal goods and labor saving conveniences, mother's nutritional status, child development</li> </ul>

**APPENDIX 5 WSP Subprojects Model Categories and Findings — continued**

Title	Gender Norms	Life Stage Personal Factors	Family Planning Programs	Contraceptive Use/ Non use	Pregnancies/Child bearing	Psychological/Physical Well being	Household/ Family Roles	Societal/ Economic Roles	Findings
Cebu Longitudinal Follow Up Study	X	X		X	X	X	X	X	<ul style="list-style-type: none"> <li>High levels of current use (60%)</li> <li>Use increased spacing but did not reduce number of children</li> <li>Earnings of working women negatively related to number of children</li> <li>Women's burden of domestic work increased with small children in home</li> <li>Family planning decision making is a dynamic process that changes over the life course (qualitative data)</li> <li>Majority of women reported making most recent family planning decision (quantitative data)</li> <li>Men make the major household decisions</li> <li>Family planning is secondary to good relationships with partner</li> <li>Autonomy as measured did not relate to maternal or household characteristics or social or economic status</li> <li>14% of women reported physical abuse by husband</li> <li>Abused women had significantly more pregnancies and contributed more income</li> </ul>
Economic and Psychosocial Influence of Family Planning on the Lives of Women in Western Visayas	X	X	X	X	X	X	X	X	<ul style="list-style-type: none"> <li>Moderately high levels of current use (53%) and high method satisfaction (90%)</li> <li>Use but not number of children associated with paid work</li> <li>Use associated with vocational training higher education professional advancement involvement in community but not politics</li> <li>Users more satisfied with life in general and with husbands and more likely to share decisions</li> <li>More than 33% reported physical or psychological abuse</li> <li>Side effects main reason for non use</li> </ul>
Social and Economic Consequences of Family Planning Use in the Southern Philippines	X	X		X	X	X	X	X	<ul style="list-style-type: none"> <li>Low level of current use (27%)</li> <li>46% of users had at least one unwanted pregnancy and 31% became pregnant while using</li> <li>Most women made decisions about contraceptive methods used</li> <li>25% physically abused by husband 40% verbally abused</li> <li>Abuse related to urban residence working outside home few possessions use of contraception husband taking on household roles (child care shopping)</li> <li>Domestic and income earning workload (hours/day) formal sector 10.2 informal 9.9 home only 6.7</li> <li>Larger families associated with women working more at home and for pay</li> <li>Number of small children decreased probability of women's working for pay and increased home work burden</li> </ul>

**APPENDIX 5 WSP Subprojects Model Categories and Findings — continued**

Title	Gender Norms	Life Stage Personal Factors	Family Planning Programs	Contraceptive Use/ Non use	Pregnancies/Child bearing	Psychological/Physical Well being	Household/ Family Roles	Societal/ Economic Roles	Findings
<b>LATIN AMERICA AND THE CARIBBEAN</b>									
<b>Bolivia</b>									
Psychosocial Impact of Fertility Regulation on Women	X	X	X	X	X	X	X	X	<ul style="list-style-type: none"> <li>• No marked differences between users and non users with regard to stability of couple self esteem decision making quality of life</li> <li>• Modern method use associated with reports of improved sexual life</li> <li>• Men and women wanted to avoid pregnancies most men supported family planning</li> <li>• Self esteem related to feeling healthy and being able to accomplish daily tasks</li> <li>• Men and women had different ideas about decision making and problem solving household chores important relationships and use/existence of free time</li> <li>• Women were less likely to enjoy sex and less comfortable expressing needs than men</li> <li>• Male drinking and forced sexual relations related to drinking were major problems for women</li> <li>• 84% of the women reported being verbally or physically assaulted by partner and 100% of the men reported physically or verbally abusing their partner</li> </ul>
Impact of Men's Knowledge Attitudes and Behavior Regarding Fertility Regulation on Women's Lives	X	X	X	X	X	X	X	X	<ul style="list-style-type: none"> <li>• Most men and women approved of family planning knew of a modern method felt men should be supportive of women's decisions However 59% of non users were at risk for an unplanned pregnancy</li> <li>• 95% of users satisfied with method</li> <li>• 66% of sample were current users of these 41% used modern method and 26% traditional method</li> <li>• Only half of the couples had talked about how many children they wanted</li> <li>• Women who used modern methods and/or had high self esteem reported more sexual satisfaction</li> </ul>
Access to and Use of Reproductive Health Service	X		X	X	X	X			<ul style="list-style-type: none"> <li>• Administrative cultural psychological barriers to migrant populations seeking reproductive health care</li> <li>• Providers' assessments of quality more positive than clients</li> <li>• Non users had the most negative attitudes about service delivery</li> <li>• Almost half of facilities had no reversible methods in stock</li> <li>• Providers and clients differed about waiting time and visit length</li> <li>• Little available counseling for adolescents or couples</li> </ul>



**APPENDIX 5 WSP Subprojects Model Categories and Findings — continued**

Title	Gender Norms	Life Stage Personal Factors	Family Planning Programs	Contraceptive Use/ Non use	Pregnancies/Child bearing	Psychological/Physical Well being	Household/ Family Roles	Societal/ Economic Roles	Findings
Women's Participation in the Work Force Follow Up of 1994 Demographic and Health Survey	X	X	X	X	X	X	X	X	<i>Preliminary</i> <ul style="list-style-type: none"> <li>64% of women working in 1997 up from about 58% in 1994</li> <li>Working continuously from 1994 to 1997 was associated with no children less than age 5 higher education residence in El Alto</li> <li>Contraceptive use remained the same at about 40% in La Paz use declined in El Alto due to a decreased reporting of traditional methods (34% to 27%)</li> <li>Women were aware of media campaigns for reproductive health</li> <li>37% of women experienced domestic violence 40% of those frequently</li> <li>Working in 1997 was more common among women who were working in 1994 older not pregnant and had used family planning in the past 3 years</li> </ul>
Case Study of Two Reproductive Health Programs	X	X	X			X	X		<ul style="list-style-type: none"> <li>Both programs work with a variety of women</li> <li>Both committed to integrated approach Both use non formal participatory educational methods</li> <li>Both struggle for funding and have had to cut back on health services focusing on advocacy and organizing</li> <li>One is action oriented and based on class analysis the other is process oriented and based on gender analysis</li> </ul>
Gender Guidelines and Training Project	X		X						<i>In progress</i>
<b>Brazil</b>									
Adolescent Longitudinal Study Social and Behavioral Consequences of Pregnancy among Young Adults in Fortaleza Ceara		X	X	X	X	X	X	X	<i>Preliminary</i> <ul style="list-style-type: none"> <li>Prenatal group more likely to be living w/ partner younger married or in consensual union less likely to be using contraception (12% vs 23%) or to stay in school higher self esteem postpartum</li> <li>Abortion group 53% fathers didn't know 25% mothers unhappy</li> <li>Adolescent pregnancies not synonymous with unwanted pregnancies</li> <li>By 45 days teens who aborted were significantly more likely to be in school</li> <li>By 45 days postpartum teen mothers showed significant increases in self esteem and improved relationships with mothers and had overall more positive perceptions of impact of pregnancy</li> </ul>
Comparative Study of the Impact of Female Sterilization on Women's Lives				X	X	X	X	X	<ul style="list-style-type: none"> <li>Groups similar with regard to age education ethnicity religion work status self esteem well being/quality of life relationship with partner gender issues</li> <li>Differences some unsterilized women (18%) not married had fewer children began childbearing later less knowledgeable about family planning methods higher per capita income lower family incomes</li> <li>Sterilized women happier if sterilization occurs after age 30</li> <li>Cost is a factor for women who are not sterilized</li> </ul>

### APPENDIX 5 WSP Subprojects Model Categories and Findings — continued

Title	Gender Norms	Life Stage Personal Factors	Family Planning Programs	Contraceptive Use/Non use	Pregnancies/Child bearing	Psychological/Physical Well being	Household/Family Roles	Societal/Economic Roles	Findings
<b>Jamaica</b>									
The Jamaica Adolescent Study	X			X	X	X	X	X	<ul style="list-style-type: none"> <li>Sexual activity seen as positive for boys negative for girls</li> <li>In 1995 different levels of self reported sexual activity for girls (6%) and boys (63%) age 12 reflecting societal norms</li> <li>In 1997 one year later 13% of girls and 75% of boys reported sexual activity</li> <li>Contraceptive use at 1st intercourse girls 65% boys 30%</li> <li>Teens in focus groups fairly knowledgeable about sex family planning STDs had misperceptions about pregnancy pregnancy prevention and STDs</li> </ul>
Case Study of Women's Center of Jamaica Foundation Program for Adolescent Mothers		X	X	X	X	X	X	X	Comprehensive approach to reducing repeat teen pregnancies successful has provided women with parenting skills and enabled them to complete their education and seek employment
<b>AFRICA AND THE MIDDLE EAST</b>									
<b>Egypt</b>									
Impact on Family Planning on Lives of Egyptian Women			X	X		X	X	X	<i>In progress</i>
Role of Women as Family Planning Employees in Egypt	X		X			X	X	X	<ul style="list-style-type: none"> <li>Female physicians underrepresented 48% of total range 12-93%</li> <li>Difficulties balancing needs of work family self</li> <li>Autonomy related to job status and geographic region</li> <li>Job positively related to self esteem respect from others autonomy household decision making</li> </ul>
Family Planning among Adolescent Married Women in Squatter Areas of Alexandria		X	X	X	X		X		<i>In progress</i>

**APPENDIX 5 WSP Subprojects Model Categories and Findings — continued**

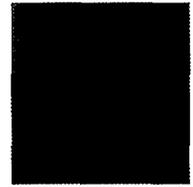
Title	Gender Norms	Life Stage Personal Factors	Family Planning Programs	Contraceptive Use/ Non use	Pregnancies/Child bearing	Psychological/Physical Well being	Household/ Family Roles	Societal/ Economic Roles	Findings
Knowledge Attitudes and Behavior Study about Reproductive Health among Adolescents and Youth in Assiut Upper Egypt		X			X	X	X		<i>In progress</i>
Family Planning Use and Offspring Gender Equity	X						X		<i>In progress</i>
Social and Behavioral Outcomes of Unintended Pregnancy				X	X	X			Unintended pregnancies more likely if older work outside of home no differences by education or residence 62% using contraception at time of pregnancy 57% pills 16% IUDs • 38% not using contraception but don't want to become pregnant • 33% had tried to abort • Son preference
<b>Mali</b>									
Impact of Family Planning Use on the Lives of New Contraceptive Users in Bamako	X	X		X			X	X	<i>Preliminary</i> • Women use family planning for more rest better health cleaner homes tranquility more money for children • Men claim authority in reproductive decisions but seldom enter household discussion of family planning • Some women start contracepting without telling their husbands fear anger and abandonment if discovered • Successful users including sisters in law are important advocates Some method change and discontinuance mainly due to side effects • Non users might use after reaching desired family size • Polygamy negatively affects use

**APPENDIX 5 WSP Subprojects Model Categories and Findings — continued**

Title	Gender Norms	Life Stage Personal Factors	Family Planning Programs	Contraceptive Use/ Non use	Pregnancies/Child bearing	Psychological/Physical Well being	Household/ Family Roles	Societal/ Economic Roles	Findings
<b>Zimbabwe</b>									
Impact of Family Planning on Women's Participation in the Development Process	X	X		X	X		X	X	<ul style="list-style-type: none"> <li>• While use is high and fertility has declined women remain marginalized in economic and political sectors</li> <li>• Women who start contraception early are more likely to be currently working</li> <li>• 90% do not use family planning at first sex</li> <li>• Use typically starts after first birth</li> <li>• Family members (spouses in laws) wanting large families have influence</li> <li>• 92% thought family planning contributes to success of women</li> <li>• No association between family planning and community participation</li> </ul>
Impact of Family Planning on Academic Achievement and Vocational Goals of Young Women				X	X	X			<ul style="list-style-type: none"> <li>• 59% of teacher training college students (32% married 14% widowed or divorced) were sexually active</li> <li>• 66% did not use contraception at first intercourse</li> <li>• 83% of sexually active students usually use contraception</li> <li>• Community mothers more likely to want family planning after desired number</li> <li>• Very difficult to get information about family planning in secondary school only 40% knew about family planning before college</li> </ul>
Mediating Effects of Attitudes of Significant Others on Women's Participation in Development	X	X		X	X		X	X	<p><i>Preliminary</i></p> <ul style="list-style-type: none"> <li>• Mothers in law encouraged family planning but only after daughters in law achieved desired family size</li> <li>• Men the ultimate authority in the home</li> <li>• Most men supported family planning</li> </ul>
Consequences of Family Planning on Women's Quality of Life	X		X	X			X	X	<ul style="list-style-type: none"> <li>• Men and women tended to agree on burdens women bear and their lack of free time</li> <li>• Women felt they should have greater participation representation and recognition in the political realm</li> <li>• Quality of life (QOL) has physical social cultural mental and spiritual components</li> <li>• Women's main indicator of QOL was planning for and being able to care for children Men believed women's QOL depends on success of women in their domestic role</li> <li>• Women cited deficits in family planning services (including cost availability and lack of information) as constraints on family planning use</li> </ul>

## APPENDIX 6

### THE RESEARCH PROCESS



One of the tenets of the Women's Studies Project (WSP) was that the research process was as important as the research results. The WSP was dedicated to the inclusion of women's voices in discussions about family planning and reproductive health. Project staff did not focus on speaking for women, rather they were catalysts, striving to create, manage, and monitor an evolutionary process that would provide a space where women could speak for themselves and participate with others in research. That process involved bringing together three groups represented in the WSP triangle — women's advocates, policy makers/providers, and researchers — plus in country donors.

A second tenet of the WSP was that context important. The WSP developed subprojects in a variety of contexts and, in each case, the research process was in large part determined by the individuals involved, their culture and gender norms, and national political settings. The WSP strove to support research projects that were tailored to individual country needs and interests. To ensure this, the WSP (1) conducted intensive in country needs assessments, (2) established In country Advisory Committees (IACs) that brought together the key groups in the triangle, (3) carefully selected participants and subprojects, (4) provided technical assistance, with the aim of building local capacity, (5) encouraged new research processes and approaches, and (6) emphasized dissemination as an element of the research process.

The WSP has, throughout its five years, devoted resources toward maintaining comprehensive process documentation files and informally conducted a mid project process monitoring

procedure that provided the basis for this section. After a general discussion of these key process elements, two case studies are presented, designed to point out similarities and differences and the role that context played in the research process.

#### COUNTRY SELECTION

The first step in the process was to identify countries where the WSP goals and the country interests were compatible. During initial in country needs assessments, FHI conducted preliminary visits with researchers, representatives of U.S. Agency for International Development (USAID) Missions, nongovernmental organizations (NGOs), Ministries of Health (MOH), and women's advocates.

These preliminary visits enabled the host country and FHI to determine the appropriateness of country inclusion in the WSP. Country selection was based on: 1) USAID Mission interest, 2) host country interest, 3) the potential for women's groups, family planning professionals, policy makers, and researchers to work together, 4) the country's research capacities, 5) FHI's work experience in the country, (6) use of family planning, with a goal of having countries that represented a wide range of contraceptive prevalence, and 7) women's status. It took approximately one year to select the six WSP emphasis countries, which provided a range of environments for study. During the selection process, WSP staff collected information on demographics, family planning services and utilization, women's status and activities, and cultural and political norms. This work supported the WSP's efforts to select research that reflected the individual country's needs and goals.

## **PROJECT MANAGEMENT, IACS AND SECRETARIATS**

One of the challenges for the WSP was to ensure that the research agenda was locally defined and locally driven. To do this, an IAC was established in emphasis countries and included members of the WSP triangle. The WSP believed that the perspectives of researchers, advocates, and policy makers and providers were necessary to ensure selection of research subprojects that reflected country needs, reinforced the relevance of advocacy to research, encouraged local ownership of the research, and ensured that study results would be disseminated to and understood by those who develop, implement, or use reproductive health policies and services.

The selection of IAC members was a key activity. Members had to be willing to work with others and with a USAID funded project and to believe that research could improve family planning services and women's lives. IACs needed to be flexible enough to allow changes in membership, due to personal or professional conflicts, but stable enough to ensure Project continuity.

While the IAC's role was advisory, management of research and dissemination activities was the task of the in country secretariats. Secretariats were identified in each emphasis country to ensure that activities were locally administered. In the Philippines, a women's professional organization served as the secretariat. In Egypt, Brazil and Bolivia, existing FHI offices performed the secretariat's role. In Indonesia, a reproductive health service organization acted as secretariat, while in Zimbabwe, the secretariat was at the University of Zimbabwe.

## **PARTICIPANT AND SUBPROJECT SELECTION**

After affirming country objectives with the IACs, the WSP sent requests for proposals to in country researchers. Researchers, in turn, sent concept proposals to FHI, where WSP staff reviewed them. The WSP staff developed a list of high priority concept proposals in collaboration with USAID/Washington. Afterward, WSP staff presented concepts to in country USAID Missions to discuss Mission priorities, interests and funding. Researchers were asked to develop and submit full proposals, including budgets and work timeta

bles, which were again reviewed by WSP staff USAID/Washington and USAID Missions (IACs did not actively participate in this selection process, many were reluctant to rule on their own colleagues' proposals, and the IAC meeting schedules did not coincide with the review process). The WSP staff, in concurrence with USAID, made the final selection of research subprojects.

Subprojects varied greatly because of differences among countries in sociocultural context, political environment, economic opportunity, status of women, the presence and status of women's advocacy organizations, level of NGO activity, experience of the selected researchers, and national perceptions of reproductive health issues. Some subprojects, such as one in Bolivia, focused on service delivery at a single institution. Others looked at larger issues, such as subprojects in Zimbabwe that addressed women and development. Some WSP subprojects used couples as units of analyses, others women only. Most studies used multiple research methods, while a few were straightforward surveys or secondary data analyses.

The role of women's advocates and organizations also varied, depending on their willingness to work with USAID funded projects and their interest in and experience with research. In some countries, such as Indonesia and Egypt, it was difficult to identify advocates as a separate group, since researchers were often considered to be advocates, and women's organizations were not necessarily advocacy groups.

However, concerted efforts were made in all in country subprojects to involve women's advocates in defining research issues, planning, dissemination, and offering feedback during the ongoing study process. For example, in the Philippines, visits were made to women's groups outside of the capital to ensure that a variety of perspectives were considered. Also in the Philippines, women's groups helped researchers develop a referral sheet which was given to study participants to make them aware of other health and social services in their community. The referral sheet provided contact information for services related to maternal and child health, family planning, domestic violence and other topics.

## **TECHNICAL ASSISTANCE, CAPACITY BUILDING AND SUSTAINABILITY**

To help ensure local ownership of research, the WSP staff provided technical assistance and training to in country colleagues. The WSP technical monitors, who were all FHI researchers, worked closely with field researchers, where needed, providing assistance with proposal writing, research design, sampling strategy, instrument design, data management, data analysis, report writing, and dissemination.

For example, the WSP supported workshops on specific topics to build local capacity. Workshops on proposal development, qualitative methods, data analysis, information dissemination, and gender training were held in the Philippines, workshops on computer analysis of qualitative data were held in Bolivia and Zimbabwe, and technical assistance on information dissemination was provided by FHI staff in Egypt and Zimbabwe. In the Philippines, researchers and the in country secretariat received information on using the Internet and other health related materials, as well as EPI INFO software and text analysis software. In addition, the WSP provided a mini library to all research teams and to selected women's advocacy organizations. The mini library contained books and papers on gender and reproductive health. An informal advisory network on information dissemination was set up in each country to work on dissemination planning.

The use of qualitative methods helped explore the complexities of women's lives. Since qualitative methods were new to many researchers, WSP staff compiled and distributed a collection of recent materials on qualitative research and a manual on documentation of research for in country colleagues. Psychosocial scales that had been developed to measure concepts, such as self esteem and quality of life were collected in a separate resource book.

In addition, the WSP staff assisted field researchers with pre testing, ethical reviews and informed consent procedures, protection of research subjects, and development of measures of psychosocial factors and quality of life indicators.

## **DISSEMINATION**

The WSP considered information dissemination a key element from the outset of the Project. Staff developed a two-tiered strategy to disseminate results at the national and international levels. IACs were encouraged to think about dissemination that would be appropriate for and specific to their country. They identified individuals and groups that could help in this effort and involved them in the planning and implementation of dissemination activities. Researchers were encouraged to see dissemination as part of their research responsibility. Most important, researchers and IACs were encouraged to view dissemination as an ongoing activity that lasted throughout the life of the Women's Studies Project, involving all members of the triangle, with the goal of improving policies and services for women.

The Philippines IAC was concerned that, in the past, too many internationally funded research projects took data out of the country and published in international journals that had little or no impact on local capacity building or research utilization. Therefore, it focused on local dissemination. One researcher wrote a regular newspaper column informing the community about WSP activities. Another research organization worked through a local radio station, and took its findings to the community for discussion and feedback. Community members were asked for their input on interpretation of results, program and policy implications, and prioritization of recommendations for policy action.

Bolivia, Egypt, Indonesia, Jamaica and the Philippines held dissemination workshops and more are planned. In Bolivia, the FHI resident director used a WSP working paper on two women centered health programs as a topic for academic seminars. Three countries, the Philippines, Indonesia and Egypt published newsletters. Other countries used existing publications as vehicles for dissemination. For example, the WSP in Brazil was featured in the national popular women's magazine, *Claudia*. An FHI dissemination expert visited Egypt and Zimbabwe to provide technical assistance as sub-projects drew to a close in those countries.

The WSP also established an informal advisory network, through which in-country colleagues were invited to share dissemination strategies and voice needs for technical assistance from FHI. In response to a request from this group, the WSP established a small grants program to fund additional local dissemination activities. The WSP received 16 proposals, of which 10 were funded. Plans included street theater, workshops, and presentations to women's clubs in Bolivia, an "adolescent day" in Brazil and workshops in Egypt that will include adolescent participants, dissemination to numerous groups, including men and young people, through radio, TV, pamphlets, and presentations in Egypt, radio programs, posters, comics, a digest of findings, and community feedback sessions in the Philippines, and daytime talk show television appearances, community feedback sessions, and radio programs in Zimbabwe.

## **TWO CASE STUDIES**

While each of the six emphasis countries presented a unique and useful perspective on the WSP process, Bolivia and Indonesia illustrated some unique differences. In Bolivia, there was broad and active participation by a variety of groups and individuals who were, from the beginning, gender conscious and attuned to qualitative research. In Indonesia, the process was more closely monitored by staff at Badan Koordinasi Keluarga Berencana Nasional (BKKBN), the national family planning board, and most Project participants began with a more quantitative orientation. Following are summaries of the research process in these two WSP countries.

### **BOLIVIA**

Bolivia was identified as a potential WSP partner because its national family planning program is relatively new, modern contraceptive method use is low, the illegal abortion rate is high, and there is a strong presence of women's groups. Another crucial factor was the support for the WSP from USAID/Bolivia.

FHI staff visited La Paz for a week in July 1994 to assess local interest in the Women's Studies Project and identify possible areas of research and

collaborative organizations and individuals. Meetings were held with key research organizations, women's groups, the USAID Mission, government agencies, and a large number of international nongovernmental organizations (NGOs) active in Bolivia. All were supportive of the WSP concept. An official assessment visit was made in October 1994, during which FHI staff and consultants met with representatives of about 30 institutions — 12 women's advocacy organizations, eight research groups and individuals, six provider and policy groups, and seven donor agencies. Potential IAC members were identified.

At the same time, FHI was increasing other efforts in Bolivia. FHI established a permanent office in La Paz, and Rene Pereira, originally a member of the WSP IAC, was selected as resident advisor. Mr. Pereira acts as liaison between FHI, including WSP staff, and Bolivian colleagues.

The IAC's first day-long meeting was held in March 1995. Its primary purpose was to set a local research agenda for the WSP. There were 10 members — including four researchers (two of whom were also women's advocates) and three NGO representatives — plus 14 observers. The IAC established research priorities, including the quality of reproductive services, labor force participation of women, abortion, cultural diversity and contraceptive use, gender relations and family planning, men and family planning, women and AIDS, and adolescent fertility.

The IAC broadly solicited applications for research and received 22 proposals. WSP staff, with support from USAID/Washington and the USAID Mission, selected three concept proposals for further development. One study was a population-based survey to look at the role of men in fertility regulation, a second brought together a health planning group and an NGO to conduct a qualitative study of the impact of fertility regulation on couples and on women's lives, and the third was a follow-up of the 1994 Demographic and Health Survey (DHS) that would focus on the impact of family planning on women's economic activities. Principal investigators presented their concept proposals to the WSP staff and, based on

staff comments, refined their study designs. Proposals were then reviewed by USAID/Washington and the USAID Mission. In addition to the research projects, the WSP also funded a case study of two women centered health programs.

The second IAC meeting was held in December 1995, with nine members present. This time, the IAC focused on the three research projects and on possible future dissemination efforts. The IAC continued to meet biannually, bringing in speakers and reviewing the progress and results of WSP projects. During IAC meetings, members heard a presentation on social constructs of masculinity, they debated whether dissemination should focus on comprehensive reports or shorter summaries (both were produced), and they reviewed the two case studies.

As the research subprojects developed, FHI staff made regular monitoring and technical assistance visits, assisting with development of a questionnaire and psychosocial indicators, interviewer training, data entry programs, development of analysis plans, qualitative methods in general, presentation of results, and report preparation. The WSP provided technical assistance in the use of both qualitative and quantitative software packages, including Ethnograph, EPI INFO and SESS. FHI staff coded and analyzed some of the in depth interview transcripts in the United States in order to expedite the qualitative analysis. Among lessons learned were the amount of time required in preparing texts for use with text analysis software and the need to provide instruction at a time when it would be immediately put to use.

One important task of the IAC was to deal with dissemination of controversial findings. For example, some women's advocates questioned data from the study on men's attitudes, which indicated that barriers to contraceptive use come from couples' lack of communication rather than from men's views. In addition, WSP research explored the sensitive issue of domestic violence.

Throughout the research process, the IAC, working cooperatively with researchers and the FHI resident advisor, planned dissemination of study results. Bolivian colleagues developed

numerous strategies, with the goal of disseminating to a wide audience, including providers, study participants, women's advocates, and policy makers. Among the dissemination activities:

- The Subcommittee on Research, Evaluation, and Population Policy published one page summaries of research efforts carried out by in country research organizations, including the WSP.
- Seminars were held for a variety of audiences, including university students, groups of providers, and other interested professionals.
- Public forums were held for discussions of WSP research.
- Several newspaper articles were published about FHI's work in Bolivia.
- Scientific articles were published in Bolivian journals.
- Conference presentations were made at the American Public Health Association and Population Association of America meetings.
- A regional conference will be held in Bolivia in August 1998. WSP investigators from Brazil will attend, along with the Bolivian IAC and local and international NGOs.
- Publications are being prepared for international peer reviewed journals.
- The Bolivia case study was given to several commercial CD ROM companies and on line databases for international electronic full text publication.
- Study reports will be posted on FHI's web site and can be "downloaded."
- PROISA, one of the WSP collaborating institutions, is planning to hold discussions of their findings with "rings" of women, starting with study participants, then expanding to local grassroots groups.
- Researchers will work closely with Mothers' Clubs to disseminate findings from the study on men's attitudes.

## INDONESIA

The Indonesian government has long supported family planning. The national program is well established, pervasive and hierarchical.

WSP staff and consultants first visited Indonesia in September 1994, upon invitation by the USAID Mission. The WSP was seen by USAID and the Indonesian government as complementary to other work being done to improve the quality of family planning services for women. BKKBN, the national family planning organization, requested that the WSP research be carried out "in the Indonesian way" — that is, in a context that mirrored Indonesian culture, religion, and ethical values, with a focus on women as members of families. The Ministry of the Role of Women was particularly interested that its network of 50 women's research centers be included, possibly supported by a small grant program, unfortunately, the lack of sufficient funds prevented such a program from being implemented.

After many discussions with government officials, NGOs, research organizations, and donor agencies, FHI staff identified a wide variety of research topics. An IAC was formed, consisting of 17 members, 7 of whom also served on a technical committee that was more directly involved in WSP activities. Of the 17 members of the IAC, five were from government ministries, three from BKKBN, and the remainder from universities, institutes and women's organizations. There were 13 observers at the first meeting in January 1995. USAID recommended establishing a secretariat to manage and coordinate WSP activities in Indonesia, and the Yayasan Kusuma Buana (YKB), a local family planning foundation that provides services and conducts research, was selected. The members of the technical committee, in addition to representatives of BKKBN and YKB, included representatives of research and women's organizations. This smaller group developed a list of researchable topics for the WSP, which was then approved by the Minister for Population, who is also the BKKBN chair.

Proposals were solicited in March 1995, and 22 concept papers were submitted. Fifteen organizations were invited to a week long proposal development workshop conducted by two FHI consultants in June 1995. In August, following the second IAC meeting, four proposals were selected by FHI and the technical committee for funding.

These were studies to examine family planning and women's economic activity (from a demographic institute), women's empowerment in the family (from a women's studies group), women's psychological well being (from a social science research center), and family welfare (from a population studies center). All research institutions were based at Indonesian universities. Technical assistance was provided in the development of final proposals, which were then reviewed by FHI and USAID. As a result of these reviews, further technical assistance was provided so that the proposals would respond to USAID comments. A second set of reviews was then held, and work began in early 1996.

As in Bolivia, the IAC began discussing dissemination strategies at an early stage. Also, as in Bolivia, researchers requested a workshop in qualitative research methods, during which they conducted in depth interviews with vanguard family planning users. FHI staff made several monitoring visits and provided assistance in questionnaire design, interview methodology, subproject planning, data management, data analysis, and final report preparation.

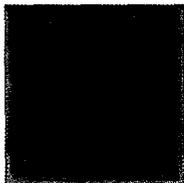
As research got under way, USAID/Jakarta asked for an earlier completion date for the Indonesia work, requiring that all four projects be finished by July 1997 and that dissemination activities be finished by December 1997. Research projects were completed on schedule, and drafts of the final reports were presented at the third and final IAC meeting in June 1997. A final dissemination meeting was held in December 1997, with an invited audience of more than 50 representatives of government and donor agencies, NGOs, researchers, and women's organizations. The meeting was chaired by Professor Dr. Haryono Suyono, Minister of Population and BKKBN chair, who said the information from these studies would be useful for extending and improving the country's family planning program. Research could be used to improve quality of services, promote greater involvement of men in family planning programs, and ultimately enhance women's empowerment. Additional dissemination efforts include broadcast of a one day workshop for policy makers and publication of a special edition of the *Indonesian Journal of Population* to disseminate results of all four studies in English and Bahasa Indonesian.

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