

Network

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**Family
Planning
& Women's
Lives**

News Briefs

N-9 CONDOM LUBRICATION

Condoms lubricated with silicone provide as much protection against sexually transmitted diseases (STDs) as do condoms lubricated with the spermicide nonoxynol-9 (N-9), concludes an FHI study.

This study, published in the April issue of *Sexually Transmitted Infections*, is the first human-use analysis of the effectiveness of N-9 lubricated condoms against STDs, compared to condoms with plain lubrication.

"Plain silicone-lubricated condoms are as effective as N-9 lubricated condoms, cost less, have a longer shelf life, and therefore may be the better condom to provide," scientists conclude in the study. Condoms with N-9 have a shelf life of two to three years, compared to five years for silicone-lubricated condoms. Some people, however, may prefer the feel of a condom lubricated with N-9 to other condoms.

The study followed 106 commercial sex workers in the Dominican Republic over 24 weeks, comparing infection rates among those who used N-9 lubricated condoms to those who used plain lubrication. The infection rates in the two groups were similar with no statistically significant differences. For cervical infections, there were 3.4 cases per 100 person months in the N-9 group, compared to 2.8 cases with plain condoms, and for trichomoniasis, 2.8 cases for N-9 and 3.6 for plain lubrication.

FHI'S N-9 TRIALS BEGIN

Nearly 2,000 volunteers throughout the United States are beginning a three-year study managed by FHI to determine the contraceptive effectiveness of various products containing the spermicide nonoxynol-9 (N-9).

N-9 products differ both in dosages and the medium used for delivery. The study, financed by the National Institutes of Health, will evaluate five types of spermicidal products: vaginal contraceptive film, a suppository and three gel products. Although N-9 spermicides have few known side effects, their safety will also be evaluated. Study participants will be asked what they like or dislike about the products.

Like other barrier methods of contraception, the effectiveness of N-9 spermicides in preventing pregnancy depends greatly on whether they are used consistently and correctly. They are known to be less effective than other modern reversible contraceptives, such as birth control pills, injections and intrauterine devices (IUDs). Previous small studies have estimated a wide range of N-9 effectiveness rates, from less than 5 percent failures in the first year of use to more than 50 percent failures.

Findings from the study may help guide the development of new spermicidal products, and should give current N-9

users more accurate information on product labels. N-9 is one of the oldest contraceptive products in use, available in the United States for more than 40 years without prescription.

AFRICAN WOMEN WANT SMALLER FAMILIES

Sub-Saharan African women increasingly want to limit the size of their families, according to Population Action International (PAI). Meanwhile, contraceptive use in the region is growing.

The ideal family size has generally decreased over the last two decades, according to PAI's recently published *Africa's Population Challenge: Accelerating Progress in Reproductive Health*. This is especially true in Kenya, where ideal family size dropped from seven to four, and in Nigeria and Senegal, from eight to six. The number of women wanting no more children — about a quarter of married women surveyed — has tripled since the 1970s, says the report.

"Some of the family planning programs in sub-Saharan Africa are very young, but we are seeing shifts in attitudes that are already changing childbearing patterns dramatically or have the potential to do so," says Shanti R. Conly, PAI policy research director and co-author of the analysis, which is based on national statistics, published research and interviews with health officials and policy-makers.

Factors decreasing the desire for larger families include urbanization, improved child survival, and rising costs of education and other basic needs.

Demand for family planning has increased dramatically in some countries, although use generally is still low across the region (18 percent of all married

women of reproductive age). Contraceptive use has increased to nearly 50 percent in Zimbabwe and over 30 percent in Botswana and Kenya.

While demand for contraceptives is increasing, unmet need for family planning remains higher in Africa than for any other region of the world. An estimated 22 million women (26 percent of married women of reproductive age) say they do not want to become pregnant yet use no contraception.

FOUR MILLION FEMALE CONDOMS

Four million female condoms have been sold to 16 developing countries this year, as part of a Joint United Nations Programme on HIV/AIDS (UNAIDS) project.

Of the countries, South Africa, Uganda, Zambia and Zimbabwe have had the most substantial sales. The condoms sell for about U.S. 50 cents to 90 cents each under a pricing agreement aimed at encouraging their use.

"The fact that Africans are coming together to support the use of the female condom is a sign of their great concern about the spread of sexually transmitted diseases and HIV/AIDS," says Dr. Elhadj Sy, leader of the UNAIDS Intercountry Support Team for Eastern and Southern Africa. Growing acceptance of the female-controlled barrier method also indicates the "growing strength of African women in determining their own means of protecting themselves" from both unwanted pregnancy and sexually transmitted diseases, he says. Since 1993, when the device was approved for use in the United States, about 18 million have been sold worldwide.

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To obtain a free subscription, please write to Ms. Debbie Crumpler at the above address.

Phone: (919) 544-7040
Fax: (919) 544-7261
Home page: <http://www.fhi.org>

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A woman from the delta region of Senegal is featured on the cover (UN Photo/153753/John Isaac).



INTRODUCTION

How Family Planning Use Affects Women's Lives

By Nancy Williamson, PhD
Former FHI Women's Studies Project Director

Note: Dr. Williamson led the Women's Studies Project from its inception until August, when she joined the Frontiers in Reproductive Health project, serving as global operations advisor. FHI and Tulane University School of Public Health are partners with the Population Council in the Washington-based Frontiers project.

Many studies have examined how aspects of women's lives influence their use of family planning. When FHI's Women's Studies Project (WSP) began in 1993, researchers reversed the equation, exploring how family planning use affects various aspects of women's lives.

Whether women felt they had or had not benefited from family planning methods and services, and if so, how, were central questions. In order to determine women's perspectives on this issue, in-country researchers as well as FHI staff went directly to the women themselves, asking them which research issues were important to study.

Twenty-six field studies were conducted in 10 very diverse developing countries, using both qualitative and quantitative research methods. Women expressed their views on family planning by completing surveys and by participating in focus group discussions and in-depth interviews. Additional information was obtained from secondary analyses of data from four countries as part of the project, which is supported by the U.S. Agency for International Development.

The project sought to look beyond the narrow focus of the impact of family planning on women's health. Studies also 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 variety of the project's research topics reflects the diversity of women's concerns:

- 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)



- family planning and women's participation in the development process (Zimbabwe)
- strategies developed by new users to cope with family and community opposition to contraceptive use (Mali)
- generational differences in family planning use (China).

These topics and others were selected by colleagues who formed in-country advisory committees (IACs) in participating countries. Researchers, policy-makers and providers, and women's health advocates formed an IAC "triangle," which became a critical component of the research process, in each emphasis country (countries that were the site of more than one study). The IACs established the research agenda, monitored the research process and planned dissemination of research results.

To guide research and data analysis, the project staff 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 and experience with family planning; and placed family planning in the context of women's larger reproductive health needs.

COMMON ISSUES EMERGE

The completed 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, common issues emerged, which were formulated into 16 crosscutting themes.

There were two general themes: that gender norms (the roles prescribed by society for women and men) play a significant role in shaping women's family planning experiences and that family planning affects multiple domains of women's lives —

domestic, economic and community. The other 14 themes are more specific, and address benefits to women, costs to women, barriers to contraceptive benefits and service delivery issues.

BENEFITS TO WOMEN

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

• Family planning can offer 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 often more likely than non-users to take advantage of work opportunities.

• Family planning helps women in their roles as wives and mothers, but it is only part of what women need to attain

equal opportunity with men in society.

COSTS TO WOMEN

• Contraceptive side effects are a serious concern for many women.

• 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.

BARRIERS TO CONTRACEPTIVE BENEFITS

• Social, political and economic barriers prevent women from benefiting from family planning.

• The benefits of family planning for women 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 women's experiences with family planning.

• Family planning is often 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.

These themes are described in greater detail in the project's synthesis report, *Women's Voices, Women's Lives: The Impact of Family Planning* (see page 36 for details on how to order a copy).

One of the main purposes of the project was to encourage the use of research findings to improve the quality of women's reproductive health services. Indeed, the results have clear implications for health policies and programs.

For example, contraceptive counseling must take into account gender norms, the barriers these norms may pose to family planning, and whether women benefit from family planning use. Peer networks, in which experienced contraceptive users counsel new users about the everyday realities of method side effects, should be established.

Men and other key family members need to be informed and educated about family planning. Providers need better training on how to assist clients experiencing contraceptive side effects. Counseling should emphasize the benefits of contraceptive use beyond health and economics, including emphasis on improvement in marital relationships. Family life education should begin early.

The project 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.

By understanding the intricate realities of women's lives and the factors that affect their reproductive health, family planning programs can offer services that match women's needs and ultimately can help improve the quality of women's lives.



DR. NANCY WILLIAMSON

JERRY MARKATOS



Contraception Influences Quality of Life

Health and relationships with others are among ways family planning use relates to quality of life.

A person's quality of life depends not only on good health and physical well-being, but on a variety of other circumstances. These include family stability and harmony, the welfare of children, and freedom to enjoy various activities including leisure, education or community pursuits.

Family planning can influence nearly all of these aspects of quality of life, according to FHI's Women's Studies Project (WSP) research conducted in 10 countries. The degree to which family planning has an impact, however, is often influenced by beliefs and practices that define gender roles, religious norms that may discourage contraceptive use, and economic and political conditions.

For example, a woman whose in-laws want many grandchildren and whose husband has other wives bearing his children may define a good life as having many children herself. In contrast, a woman may think quality of life means having only one or two children to ensure that each is well-fed and educated. Or, another woman may value time to pursue educational or professional goals.

The many ways family planning use influences quality of life range from those that are strictly personal, such as an individual's health status, to factors that are shaped by relationships with others.

HEALTH BENEFITS

Family planning offers women clear health benefits. In developing countries, complications related to pregnancy and

childbirth are a common cause of death. By allowing adequate spacing between pregnancies, preventing pregnancy very early or late in women's reproductive lives when risks are greater, and avoiding unintended pregnancies that may lead to illegal and dangerous abortions, family planning can protect women's health.

Research shows that many women recognize these benefits. In Mali, where less than 5 percent of married women of reproductive age use a modern contraceptive method, new users of modern contraception in Bamako said they chose to contracept primarily because they wanted to restore or maintain their health. "I want to have a rest," said one woman in a WSP study of 55 contraceptive users. "It is the first time that I have weaned a baby before having another pregnancy." Another explained: "The woman who has close pregnancies is exhausted. But when you space your children, you are in peace. It avoids sicknesses."¹

In an FHI study of about 800 women in Lampung and South Sumatra, Indonesia, women with only one or two children reported feeling greater vitality (defined as having no health problems and "feeling okay") than those with more than two children. Women also reported feeling more attractive. "If we always give birth, our body will shrink," explained one Indonesian woman. "It gets skinnier fast, older fast."²

Relief from the burden of childbearing and rearing also was seen as having psychological benefits. In focus group discussions with more than 130 women and men from Mashonaland East province, Zimbabwe,

both men and women defined quality of life as peace and happiness in the home, and said family planning was an important element of quality of life. Women particularly valued having time to nurture their families.³

Studies of contracepting women in El Alto and Cochabamba, Bolivia, showed that modern contraceptive methods were associated with increased sexual enjoyment, possibly because they reduced fear of pregnancy.⁴ However, contraception appeared to reduce libido for other women. Contraceptive side effects, as well as the fear of pregnancy, can reduce a woman's sexual desire.

All too often, unintended pregnancy occurs because contraception was used incorrectly or inconsistently, discontinued early or the method chosen was not effective. In a WSP study conducted from 1995 to 1998 in collaboration with Xavier University researchers, 31 percent of about 1,250 Filipino women who had ever used family planning reported a pregnancy while using contraception, primarily IUDs or pills.⁵

In contrast, a survey of 236 women in Campinas, São Paulo, Brazil, who had undergone tubal ligation, found overwhelming (90 percent) satisfaction with this highly

effective method. Because sterilization is permanent, however, it may not be the best choice for some men and women, especially those who are very young, since their decisions about having children may change later in life. In the Brazilian study, women younger than 25 years old at the time of the ligation were more likely than older women to later regret having been sterilized.⁶

SERVICE DELIVERY INFLUENCES

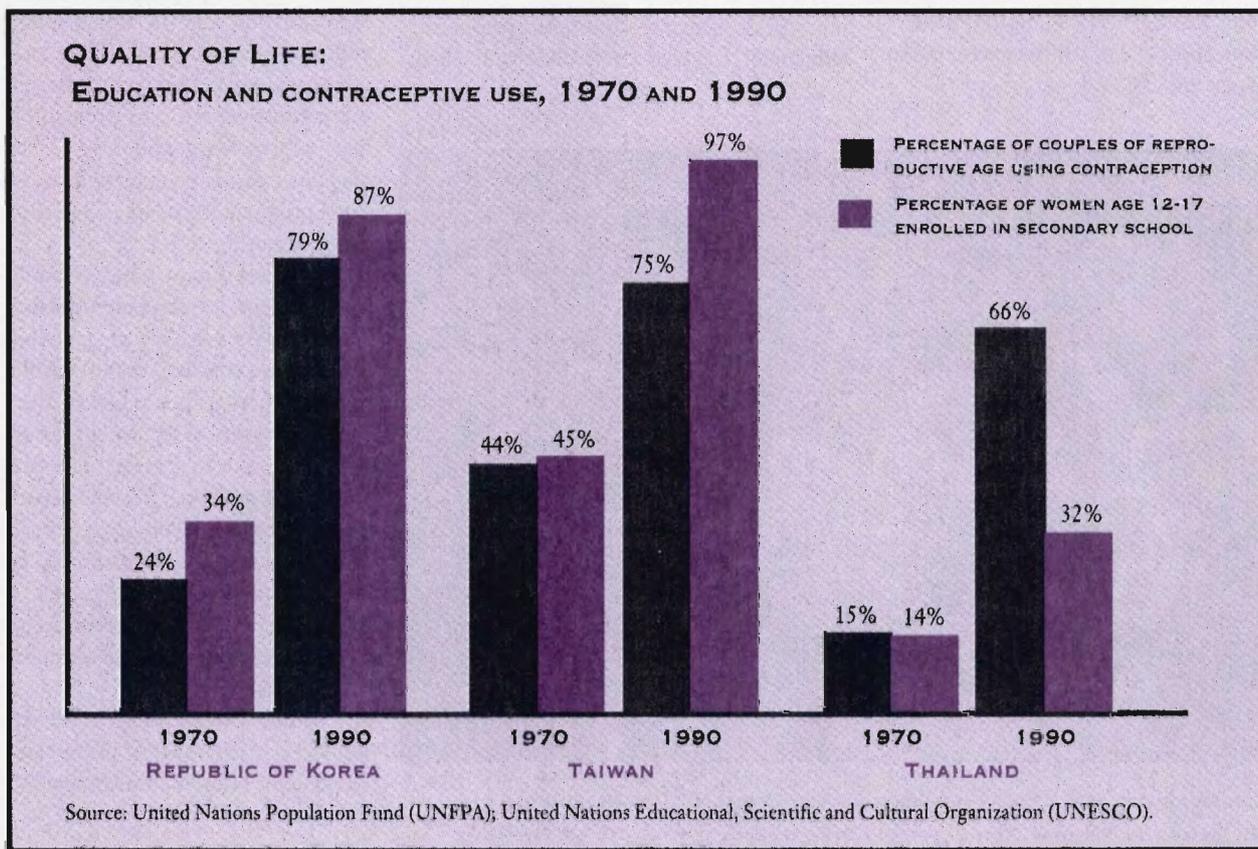
How contraceptive services are delivered influences the way couples perceive the benefits of family planning, thus affecting their quality of life.

Many clients in El Alto, Bolivia, were dissatisfied with the treatment they received at clinics, including long waiting times, short consultations, discrimination against women who wore the traditional female dress of the Altiplano, and lack of access to reversible contraception.⁷ Throughout Indonesia, women complained about services, particularly the great distance between home and service site, long waits, unfriendly providers and unavailability of desired methods.

In addition, distress with side effects was exacerbated when systems of referral were poor. In Bangladesh, women complained that door-to-door contraceptive distribution meant help was seldom available when side effects occurred.⁸

Even women who recognize the health benefits of family planning complain that they do not get enough information about contraceptive side effects. Many women say that providers typically minimize side effects. Unexpected side effects later cause them to stop using contraception.

Side effects are a serious concern for women who use contraception. In FHI's Lampung and South Sumatra, Indonesia, study, 31 percent of contracepting women reported experiencing a "major" problem related to their method. A frequent complaint was headaches, most commonly experienced by users of the pill, injectables and implants. Menstrual irregularities often disturbed users of injectables or IUDs, and could reduce quality of life for Moslem women whose religion teaches that a menstruating woman should not fast, pray, have sex or touch holy books.



Adequate counseling about side effects also helps to address misconceptions, which can discourage women from using family planning. In Cochabamba, Bolivia, 95 percent of approximately 600 couples interviewed in a WSP study were satisfied with their current contraceptive method (generally IUDs or condoms), but about 15 percent believed various myths associated with pills, tubal ligation, IUDs or condoms.⁹

FAMILY HARMONY

Women often equate their own happiness with that of their families; thus, the impact of family planning on their household is critical.

Contraceptive users in Malaysia were significantly less likely than non-users to report marital disruption, perhaps due to better communication between spouses.¹⁰ Contracepting couples in the Zimbabwe study described more peace and happiness in their homes than couples who were not using contraception. In the Cochabamba, Bolivia, study, current users of contraceptives were more likely than non-users to report better relationships with their partners.

Nevertheless, in Mali, family planning use frequently caused disagreements. One study found that the husband disapproved but the wife approved of contraceptive use in about 20 percent of couples.¹¹

The reaction of other family members can be crucial to family planning decisions, and how those decisions affect quality of life. Husbands, in-laws and others can hold strong opinions against contraceptive use, seeing it as an obstacle to the extension of the family lineage or a challenge to traditional views about family authority (see related article, page 10). In many cultures, women gain status through childbearing. Also, having many children represents security later in life, when children support their parents. In another Zimbabwe study by FHI, most older women, particularly in rural areas, wanted their sons to have large families not only to help with household chores, but to look after them in old age.¹²

Financial security influences family planning decisions in other ways. Some FHI study participants pointed out that income, rather than family size, determined a family's general welfare. In a WSP study conducted in Central and East Java, in collaboration with the Population Studies Center, Gadjah Mada University, a 32-year-old Indonesian mother of two children commented, "It does not matter how many children we have. All depends on how hardworking we are in looking for a livelihood. It [many children] is not a problem if one's income is large."¹³ Others, however, do associate educational prospects with family size. Said a man from rural Chivi,

Zimbabwe: "I like the idea of using [a] family planning method because when I grew up we were so many in our family, and this 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."¹⁴

EDUCATION AND WORK

One benefit clearly attributable to limiting family size is more free time for women, which could be used to devote more attention to family, work or other interests. Of 871 contracepting women who were surveyed in the study in Central and East Java, Indonesia, approximately 86 percent said family planning resulted in more leisure time. A study conducted in the Philippines illustrates part of the reason why: Considering all children under the age of 18, each child increased the women's domestic work by about 16 minutes per day. The younger the child, the greater was the domestic burden, with infants requiring more than two hours per day.¹⁵

Contraceptive use is clearly associated with gains in women's education. In a study conducted in Mutare, Masvingo and Harare, Zimbabwe, many female students reported high academic and vocational ambitions, but educational avenues often closed when young women became pregnant. Of 27 girls in the study who became pregnant in primary or secondary school, 67 percent dropped out; of 36 young women who became pregnant in college, 78 percent dropped out.¹⁶

In South Korea, where a family planning program was implemented in 1962 and contraception is widely used, young women are far more educated than their mothers or grandmothers. Women had an average of only three years of formal education in 1960, compared with an average of more than eight years in 1990.¹⁷ Women's enrollment in secondary school in South Korea, Japan, Taiwan, Singapore, Thailand and Indonesia increased markedly between 1960, when women had on average six children, and 1990, when women had on average two children or fewer.¹⁸

When women pursue more education, training, employment or professional advancement, household income may increase.

RICHARD LORD



CONTRACEPTIVE SERVICES CAN INFLUENCE QUALITY OF LIFE, INCLUDING FAMILY STABILITY AND HARMONY. THIS EGYPTIAN FAMILY INCLUDES TWO YOUNG DAUGHTERS.

However, the ways in which family planning affects women's work opportunities, income and power vary dramatically from place to place (see related article, page 19).

In a WSP study in Zimbabwe, most older women, whether rural or urban, said the number of children did not affect a woman's ability to get an education. Mothers-in-law, particularly those from rural areas, said they could care for grandchildren while daughters-in-law continued their education or job training.¹⁹ But this same study also revealed that men often supported the idea of their wives pursuing an education and their use of contraception to achieve that goal. "With the current economic environment," said one urban man, "if a woman is educated, it is good for her to get more education. If she doesn't go [to school], you will be letting wealth rot."

Whether contracepting women have more influence in making household decisions than those who do not use family planning varies widely. Often, decision-making is associated with work status. In Egypt, for example, family planning employees said their work gave them knowledge and experience that helped them make decisions with their husbands, including decisions about their daughters' age at marriage and their own contraceptive use.²⁰ A WSP collaborative study with researchers at Central Philippines University found that in Western Visayas, the Philippines, more family planning users than non-users shared decision-making with their husbands on matters regarding whether the woman could work outside the home, travel outside the community, use family planning, and have another baby.²¹

However, in Zimbabwe, women, men and mothers-in-law were unanimous that the number of children a woman had did not affect her ability to decide about household expenses. One rural woman said: "Making

decisions depends on one's intelligence and intelligence has nothing to do with how many children a person has." A man from rural Chivi pointed out that "it depends on how a couple gets along since they got married. If you oppress your wife and do not allow her to make decisions in the household, it will never change. So there would be no difference."²²

youth, despite a long history of contraception in the country, follow traditional gender norms and roles when talking about their future spouses: Young Chinese women say a woman should have a career before marriage, because housework and childcare are a wife's responsibility. In Bangladesh, women remained subservient to men and socially isolated even after contraceptive use increased. In South Korea, women have

achieved significantly better educational and work opportunities, but without changes in traditional gender roles that define men as breadwinners and women as homemakers responsible for housework and nurturing children. In Indonesia, gender roles are specified by law.

By giving women more time for activities other than childcare, family planning may increase women's opportunities to take part in civic activities. But women's involvement depends greatly upon cultural norms. For ex-

ample, one WSP study in Zimbabwe found that social pressures discouraged women from political participation. "No one will listen to a woman leader," states a young woman with children from rural Chivi. "We are always under men." Zimbabwean urban men generally tended to oppose married women attending political meetings, believing they would be hard to control and more likely to engage in extramarital affairs.

Even when women perceive contraceptive use as a way to improve the quality of their lives, WSP studies show that family planning, and the resulting smaller family size, is seldom viewed as an end in itself. Instead, controlling family size is simply one step on a long continuum of social and economic factors that may improve the quality of life for all family members.

— Kim Best

Continued on page 33

CINDY REIMAN/IMPACT VISUALS



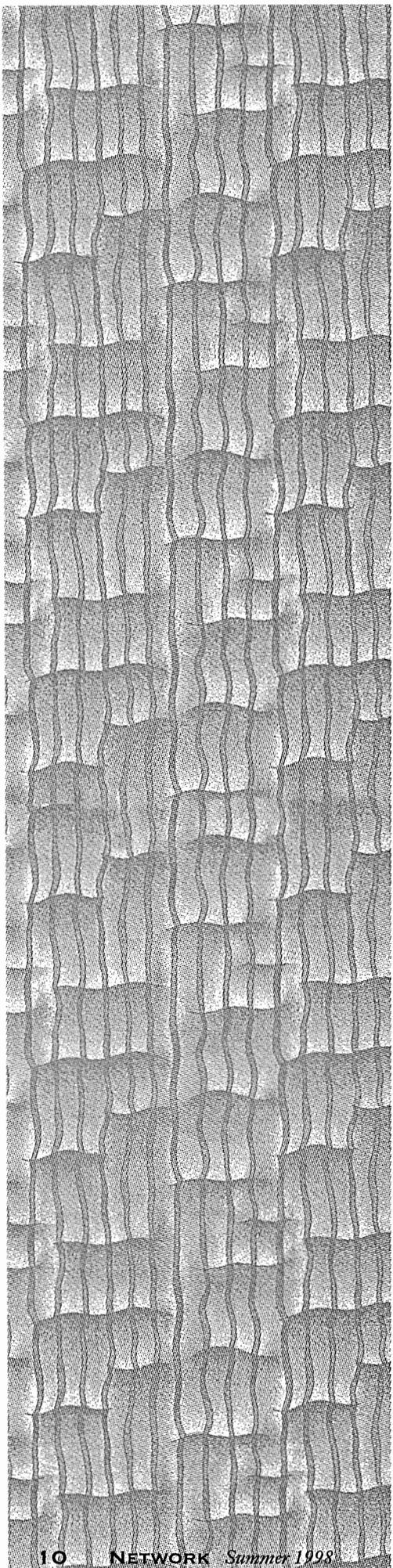
FAMILY PLANNING USE MAY INCREASE WOMEN'S OPPORTUNITIES TO PARTICIPATE IN CIVIC ACTIVITIES. A WOMAN IN MEXICO CITY TAKES PART IN A POLITICAL EVENT.

COMMUNITY LIFE

Women repeatedly told researchers that their roles as mothers not only fulfilled them, but earned them the respect and approval of families and peers. In Zimbabwe, tradition links a woman's spiritual growth to childbearing. In Mali, children are considered social wealth.

Contraceptive use among single women is often equated with immorality or promiscuity. Researchers from the University of the West Indies and FHI found in focus group discussions that Jamaican adolescents expressed positive attitudes about contraception and agreed that its use indicated responsible behavior, but said contraceptive use also implied sexual activity, which is forbidden for young adolescent girls.²³

Religious, cultural or gender norms define community life and can influence decisions about contraceptive use. Chinese



Family Planning Use Often a Family Decision

Better ways are needed to involve relatives, who may influence contraceptive choices.

Most contraceptive methods are designed for use by women, and as a result, most family planning programs target their information, counseling and services to women of reproductive age.

However, this limited focus ignores an important reality in women's lives: Women often are not the sole decision-makers about contraceptive use. Some make decisions about family planning and family size in collaboration with their husbands or partners. Others have little or no autonomy in the home, and husbands, partners, parents or in-laws decide for them. And others use contraception clandestinely, fearing relatives will disapprove.

Health program providers need to recognize that family planning is often a family decision. Providers should look for ways to inform, involve and educate relatives, who may have a tremendous influence on whether contraceptive use begins, when it begins, whether it continues, who uses contraception and what methods are used.

The influence of husbands and other family members was one of the topics explored by researchers in the Women's Studies Project (WSP) at FHI. In analyzing results from 10 countries in the project, researchers concluded that family members, particularly husbands, play a critical role in women's family planning use and continuation. When partners or other relatives are opposed to family planning, women can face severe consequences, including divorce or abandonment, and violence, ridicule or disapproval from family, friends or their partners.

COUPLES' DECISION-MAKING

When surveyed about decision-making in the home, the majority of women in the 10 countries said their husbands or partners were usually involved in contraceptive discussions, although the nature of that involvement varied. Some men were involved by supporting women's contraceptive decisions, other men used methods themselves, and others posed obstacles for women's use of family planning.

In Cebu, the Philippines, more than two-thirds of the 2,200 women surveyed about household decision-making said they would consult their husbands about contraceptive use. Some 20 percent said they would consult another adult, and only 12 percent said they would make a decision without talking to someone.¹

One Cebuano woman detailed her husband's assistance as they searched for an acceptable contraceptive: "Because of the emotional stress that I experienced after the death of four of my newborn babies, my husband suggested the use of some family planning method to avoid further stressful experiences." After difficulties with other methods, the couple decided to practice withdrawal, which requires male cooperation.

Many men in a Zimbabwe study said they supported family planning, believing it was important to women's health and was a key factor in determining the family's quality of life. "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," said one man in Mashonaland East province.² Men said

they expected their wives to initiate discussions about contraceptive use, but that husbands should be involved in contraceptive decisions.

"Traditionally, family planning was decided by both members of the couple. With the advent of modern methods, one partner became responsible, the other was left out," says Dr. Jane Mutambirwa, a social anthropologist at the University of Zimbabwe and principal investigator for this study. "Consequently, this very important role formerly played by men was no longer within their domain. Men made a point that they would like to have more contraceptive options available to them, to relieve their wives of the burden of side effects. They emphasized the need to counsel *couples*."

In Indonesia, where family planning has been widely promoted by the government since the 1970s, women in West Java and North Sumatra said couples jointly made decisions about family planning, although husbands were regarded as heads of the household, and few women used family planning without their husbands' knowledge.³ In a separate study in Central and East Java, husbands' opinions strongly influenced women's contraceptive use, although women were responsible for choosing the specific contraceptive method used.⁴

In Jakarta and Ujung Pandang, more than two-thirds of 760 married women, ages 30 to 45, said they had discussed contraception with their husbands, who saw family planning as a means to reduce the family's economic burden. In Ujung Pandang, nearly 77 percent of the 360 women interviewed said they would make a mutual decision with their husbands to have another child. Yet, 56 percent of the 400 women in Jakarta said their husbands' wishes prevailed. "As a wife, I have no freedom to decide something by myself," said a woman from Jakarta. "I have to ask his permission."⁵

AUTHORITY AND RESPONSIBILITY

Because women bear the physical burden and pain of childbearing and are primarily responsible for childcare, some women say the final decision to use family planning should be theirs. However, some men say their role as financial provider gives them authority to decide how many children the family can afford. This was the case in Mali, where a small WSP study examined the experiences of 55 first-time contraceptive users,

married women ages 18 to 45, who came to the Association Malienne pour la Promotion et Protection de la Famille (AMPPF) clinic in Bamako.⁶

Married men, mothers-in-law and women who had never used contraception also were interviewed in this study, conducted by the Centre d'Etudes et de Recherche sur la Population pour le Développement (CERPOD). Researchers found that family planning is considered the woman's responsibility, but both women and men regard decision-making as a man's domain.

In focus group discussions, men were unanimous in their opinion that women had no right to use contraception without men's permission. "When the husband says no, it means no," said one man. Another said, "If my wife makes the decision to use family planning without my consent, I will divorce her." Fewer than one-third of the men interviewed thought they would ever want their wives to use family planning.

Women who sought contraceptive services said they discussed the subject with their husbands, giving examples of how contraceptive use could improve women's health and benefit the entire family. "Your children will be well taken care of, they will eat as they should," one woman explained. Another said, "I showed him that the children are closely spaced and that life is difficult — it [contraception] would give us a rest."

In addition, women enlisted the help of other family members to convince husbands of the benefits of family planning. Older sisters-in-law proved to be powerful allies in encouraging men's support of family planning. "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 contraceptive user. Although women also relied on their husband's older aunts, younger sisters-in-law and mothers-in-law were generally less involved in contraceptive decisions. Mothers-in-law themselves said they were reluctant to discuss contraception with their daughters-in-law, and daughters-in-law said the opinions of their mother-in-law were of little consequence.

Seventeen of the 55 women who came to the AMPPF clinic did so without their husband's permission and used contraceptives clandestinely. By doing so, they risked divorce, abandonment or indifference to side effects. Most clandestine users chose injectable contraceptives, while others used pills that were hidden at work or at neighbors' homes.

In Egypt, women's subordinate position often influenced their perceptions of ideal family size, according to preliminary results from a nationwide WSP study. Fears of divorce led some women to continue childbearing, even if they did not want more

RICHARD LORD



OTHER FAMILY MEMBERS OFTEN INFLUENCE A COUPLE'S DECISIONS ABOUT FAMILY PLANNING. THIS COUNSELOR DISCUSSES CONTRACEPTIVE OPTIONS DURING A VISIT TO AN EGYPTIAN HOME.

STRATEGIES NEEDED TO INVOLVE MEN, OTHER FAMILY MEMBERS

Because women typically do not make decisions about contraceptive use and family planning alone — and because many women often have little if any decision-making power in the home — strategies to empower women and educate family members are needed.

Scientists who worked on FHI's Women's Studies Project conclude that involvement of men is essential in reproductive health programs. Policy-makers should expand male services and encourage greater use of male contraceptive methods, researchers say.

Health programs should include counseling to help women and men improve communications skills and conduct education campaigns to inform men about the roles they can play in family planning. Men should learn about side effects of both male and female methods, since concern over side effects can discourage men's support of family planning.

Strategies can be shaped to address different groups. For example, campaigns that emphasize the economic benefits of contraceptive use might appeal to husbands who provide financial support for families, while information about sexually transmitted diseases and pregnancy protection might appeal more to single men.

Some programs show how the influence of family members can help:

- In Madagascar and Bangladesh, education programs were held for some men whose wives received Norplant, the contraceptive implant. Women's continuation rates for Norplant were higher if husbands also had undergone family planning counseling. Husbands were less worried about side effects, and most clients and their husbands were satisfied with their method choice.¹

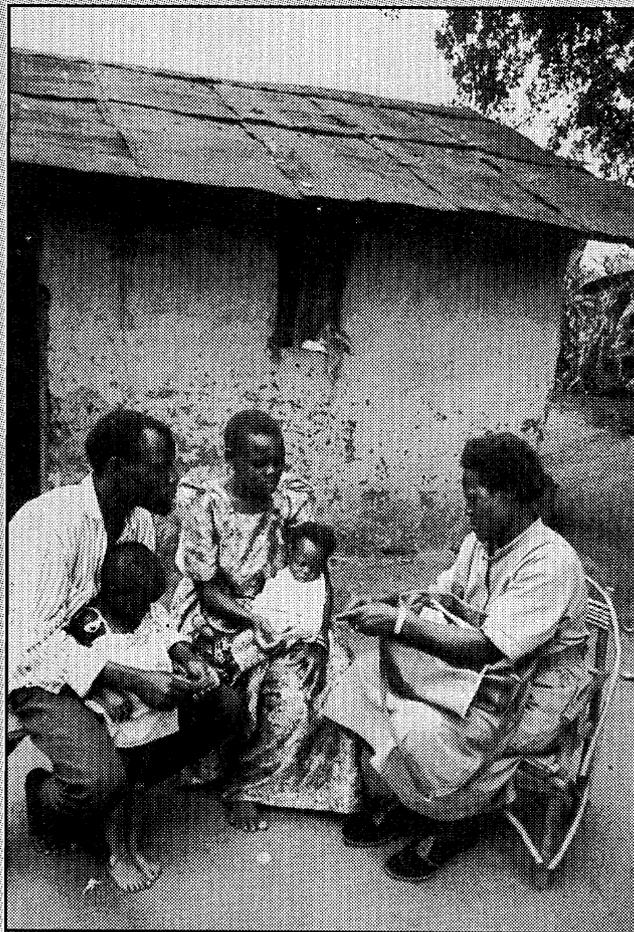
- In Honduras, CARE International trained agriculture extension agents to provide reproductive health education at meetings with farmers and helped design a family planning booklet for rural couples. Volunteers worked with couples to encourage them to discuss family size and timing of pregnancies. Men were enthusiastic about receiving reproductive health information, researchers say, and communication with their wives increased.²

pregnancy and labor, and postpartum care. Before the sessions began, only about one out of three could identify any signs of pregnancy complications. One year later, nearly everyone could name signs.³

Health experts hope programs such as these will change the perception that reproductive health is primarily a woman's responsibility, while decision-making belongs exclusively to men. Ideally, family planning use and family size should be decisions made jointly by men and women.

"What people see from family planning is the women," said Nafissatou Sidibe-Diop, a women's health advocate from Mali. "If more men were involved as providers or as satisfied users, maybe that will change the perception that family planning is only women's business."

— Barbara Barnett



A FAMILY PLANNING COUNSELOR VISITS A UGANDAN COUPLE.

- In Nepal, mothers-in-law attended education sessions on maternal health. More than 160 women, whose daughters-in-law had at least one young child, received information on prenatal care, danger signs during

pregnancy and labor, and postpartum care. Before the sessions began, only about one out of three could identify any signs of pregnancy complications. One year later, nearly everyone could name signs.³

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children.⁷ Another study, which included analysis of 1992 Demographic and Health Surveys (DHS) data, revealed that men typically want more children than women. Unless partners communicate their desires about family size, the husbands' wishes usually prevail.⁸

In Bangladesh, where women are often totally dependent on their husbands for financial support, men's views strongly influenced contraceptive use. Interviews with 104 women and 92 men found that women were reluctant to use contraception if they thought their husbands might view family planning as an economic burden. "My husband does not object to my taking pills," one woman explained. "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?'"

Elsewhere, men also played a dominant role in contraceptive decision-making. Nigerian couples said that men's views were more important than women's in family decisions. Among the more than 3,000 couples interviewed, 88 percent of men and 78 percent of women said men were the dominant decision-makers in the home. Men and women generally agreed that men decide whether the couple will have sexual intercourse, the duration of postpartum abstinence and whether the couple will use family planning.¹⁰

A Population Council study in the Philippines found that the husband's desire for more children ranked as the second most important obstacle for contraceptive use by women who wish to space or delay pregnancies. (Men and women's concern about contraceptive side effects was the premier obstacle.)¹¹ In a survey of more than 6,500 households in Turkey, one-fourth of the women said they did not want more children but did not use contraception because their husbands disapproved.¹²

But researchers speculate that the lines of authority may be less distinct in some countries. In a 1991 survey among Egyptian men, most said that husbands had the most influence in contraceptive decisions. But among men who had ever used contraception, a substantial number (about a third) said their wives played the more influential role. Researchers concluded that women play a larger role in these decisions than is openly acknowledged.¹³

That couples may not communicate well about family planning is illustrated in a WSP study in El Alto, Bolivia, which included 101 women and 31 men. Conducted by the Proyecto Integral de Salud, it found that two-thirds of male participants said that family planning was a joint decision with their partner, but fewer than half of the women said family planning was a mutual decision.¹⁴

In general, some women say they are too shy or too busy to begin discussions with their husbands; others fear their husband's response or worry that their knowledge of sexual issues could be interpreted as promiscuity or infidelity. "I express what I have to with fear, and it embarrasses me," said one woman in the El Alto study.

Another WSP study, conducted by Cooperazione Internazionale, surveyed 630 couples in Cochabamba, Bolivia.¹⁵ More than 90 percent of women and men said they approved of family planning, that their partner approved of family planning, that men should take responsibility for family planning by using male contraceptive methods, and that men should support their partner's decision to use contraception. However, only half the couples said they talked about family size, and not all couples discussed contraceptive use.

Couple communication can play a pivotal role in contraceptive use. In a study in eastern Ghana, funded by the Population Council, the Navrongo Health Research Center (NHRC) examined factors that influenced adoption of family planning methods. The NHRC conducted a pilot project and established a community-based health center and family planning services. At the time the project began, only two of the 2,000 women in the community used contraception. Within 18 months, 225 women were using family planning. The two most important factors in determining contraceptive use were communication between spouses (including wives' perception that husbands supported their contraceptive use) and communication with people outside the family who offered encouragement and support for family planning.¹⁶

OTHER FAMILY MEMBERS

While husbands and male partners have a tremendous impact on women's contraceptive use or non-use, other family members can play significant roles as well.

In some countries, parents and in-laws view grandchildren as necessary to extend the family line, to provide labor on family farms, or to provide financial support for parents during old age. They may discourage couples from using family planning to delay pregnancy, but encourage couples to use family planning to limit or space births after they have a large family.

WSP research in Zimbabwe showed that although contraceptive use is high nationwide — about 48 percent among married women of reproductive age — contraceptive use before first pregnancy is low. Only 8 percent of women use family planning at the time they marry, but after first birth, the percentage increases to 59 percent.¹⁷

"You get pressure from both your family and your husband's family to get pregnant" soon after marriage, explains Dr. Marvellous Mhloyi of the Center for Population Studies at the University of Zimbabwe, a principal investigator for one of four WSP studies in Zimbabwe. "If you do not get pregnant in three months, people will come and say, 'There is a darkness in this house.'" In addition, having children affords women more status. In another Zimbabwe study, mothers-in-law said they encouraged contraceptive use, but only as a means of limiting pregnancies once a couple had the number of children they wanted.¹⁸

Dr. Laila Kafafi, FHI senior resident research advisor in Egypt, says that many young married women may not see the benefit of using family planning to delay pregnancy. "Once you get married, you have to have a child right away," she says. "Mothers-in-law want daughters-in-law to prove fertility."

Preliminary findings from one nationwide WSP study in Egypt found that mothers-in-law influenced women's decisions about family size.¹⁹ A woman in a village near Assiut said that her mother-in-law threatened her if she did not have more children and told her she would find another bride for her son. When asked if they would advise their daughters-in-law to plan their families, one woman said, "after the first child, to know if she is fertile or not." Another said, "After the first male child." Men also suggested that couples should have a child as soon as possible after marriage. "Why else does a girl get married?" asked one man in Alexandria.²⁰

Other studies have also found that mothers-in-law and other elder family members influence women's decisions about family size. In India, 56 of the 100 women interviewed in Uttar Pradesh said they deferred to their mothers-in-law for decisions about health and child welfare.²¹ In some homes, where couples live with parents or in-laws, lack of privacy can discourage use of some contraceptives, such as the pill, condoms or a diaphragm.

In a study in Kenya, conducted in four rural communities in Nyanza province, three-fourths of the women surveyed said they discuss family planning with someone else. Most of these conversations (94 percent) involved other women, especially family members. Women said they weigh information they receive from health providers against information from female relatives and friends.²²

In Brazil, a WSP study found that some adolescent girls wanted to be pregnant, believing it would enhance family relationships.²³ Researchers interviewed 367 teens who sought prenatal care at the Maternidade Escola Assis Chateaubriand (MEAC) clinic in Fortaleza, Ceará, plus 196 teens who came to the emergency ward for treatment of complications from incomplete abortion. Among the prenatal group, only 12 percent used contraception at the time of their pregnancy, and 46 percent said they wanted to be pregnant.

During an interview, conducted during their initial visit to the MEAC clinic, pregnant teens said they thought their pregnancy would improve their relationships with parents, friends and partners. However, when interviewed at 45 days postpartum, adolescents reported that their relationships with their mothers had improved, while their relationships with their partners had deteriorated. When interviewed one year later, adolescents reported no improvements in relationships with their mothers. Relationships with partners deteriorated in both groups at one year.

In Jamaica, seventh and eighth grade girls said that their peers might be reluctant to use family planning. If parents and friends learned of contraceptive use, they would assume a girl was sexually active, which would be forbidden at a young age. One girl suggested that if a mother found her

daughter's contraceptive supplies, she "would curse her. She would think she was having sex."²⁴

— Barbara Barnett

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Abused Women Have Special Needs

Reproductive health providers are in a position to intervene, since they serve women at risk of violence.

Women's low status leaves them vulnerable to violence. A majority of women in some communities endure abuse from their intimate partners, risking their health and lives.

"He told me we were going to make love, and I did not want to," says Maria, a 32-year-old Bolivian woman who has endured years of violence from her husband. "He said, 'Why is it that you never want to?'" and began hitting her. Maria eventually fainted from the pain of his attack.

An FHI study in Bolivia, which included Maria and 131 other women and men, found that more than 50 percent of women had been physically assaulted by their partners, and a third had been forced to have sex against their will.¹ "Some men said, 'Of course we beat our wives,'" says Donna McCarraher, an FHI researcher studying partner violence in Bolivia. "And women endured being beaten."

Both men and women accept and condone domestic violence in many parts of the world. Some blame beatings on a wife's failure to bear children or to carry out her domestic duties. Others simply accept violence as a fact of married life. In population-based surveys, between 20 percent and 50 percent of ever-married women in areas as diverse as Egypt, the United States and parts of Nicaragua and Zimbabwe, reported being beaten or otherwise physically abused by their partners. Many also reported sexual or psychological abuse.²

For these women, and for countless others, such violence is part of daily life and can lead to severe injuries and other health

problems. These women have desperate needs for safety, and for medical, psychological and reproductive health care.

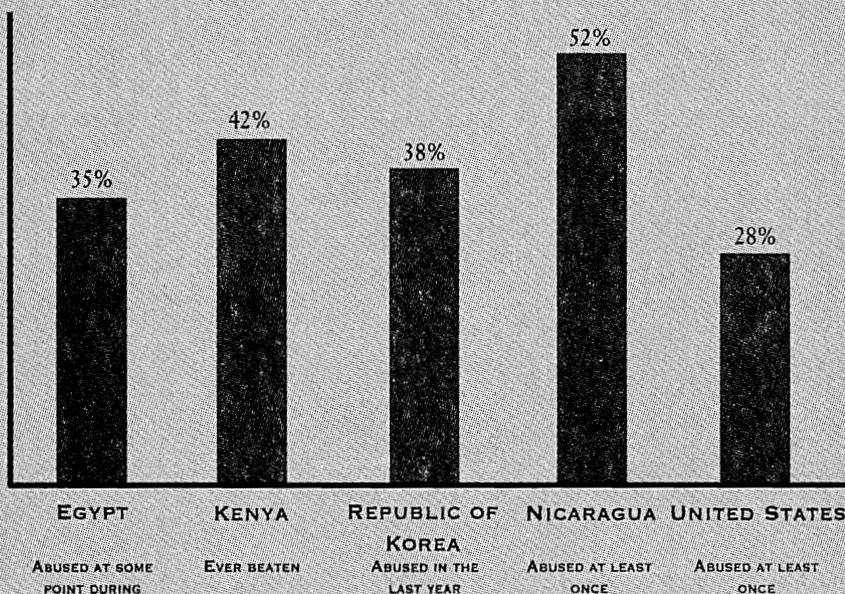
"The threat or fear of violent behavior prevents women from protecting themselves adequately from pregnancy, abortion and sexually transmitted diseases (STDs)," says Naana Otoo-Oyortey, a gender consultant with the International Planned Parenthood Federation (IPPF) in London. "It leads women to defer to male decision-making on what form of contraception they are allowed to use, which may not be what is effective or right for them."

Family planning and other health-care providers are in an excellent position to intervene because they represent one of the few institutions to come in contact with most women during their reproductive lives — the time of highest risk for domestic violence. In order to improve the quality of care for abused women, some providers have instituted violence awareness programs, screening and referral techniques.

Domestic violence and sexual coercion are just a part of gender-based violence that includes female genital mutilation, forced sterilization, dowry murders and female infanticide. These abuses result from power imbalances between men and women, experts say. Although it is rare, men are sometimes the recipients of domestic violence. FHI's study in El Alto, Bolivia, found that some women report physically abusing their male partners, often in self defense.

Family planning providers must become aware of power imbalances and the resulting health effects. "They cannot do

**DOMESTIC VIOLENCE:
PERCENT WOMEN REPORTING PHYSICAL ABUSE FROM PARTNERS**



Source: Women's Health and Development Programme, World Health Organization.

their jobs well without being concerned about how the issue of power affects women's reproductive health," says Lori Heise, co-director of the Washington-based Center for Health and Gender Equity. "If you do not know that a woman cannot control when she has sex, you are not going to counsel her appropriately. You need to know a woman's social realities."

For years, women's advocacy groups have encouraged the international community to recognize and prevent gender-based violence. As a result, the 1995 Fourth World Conference on Women, held in Beijing, emphasized violence as a critical area of concern. Some countries have recently enacted laws to allow women to divorce or prosecute abusive partners, an important step in making violence less socially acceptable.

The World Health Organization is beginning a collaborative study to examine partner violence and reproductive health in at least five countries, Heise says. Researchers hope to begin interviewing 3,000 women in each country in 1999. One of the strengths of the study is that it addresses methodological issues that plagued earlier research on domestic violence. For example, the reported prevalence of abuse depends

heavily on how abuse is defined, which survey questions are used, how and when they are asked, the skill and training of interviewers, the degree of privacy insured, and who is included in the study.

NO NEGOTIATION

Violent men typically seek control over their partner's behavior and sexuality. "Often, batterers are invested in a definition of manhood they have, including fertility," says Dr. Jacquelyn Campbell, a Johns Hopkins University researcher who studies domestic violence and women's health. Abused women are often unable to negotiate the timing of pregnancy, STD protection, or even health care, because bringing up such issues threatens their partner's sense of control or masculinity.

In a U.S. focus group study, Dr. Campbell found that violent men often dictated contraceptive choice. Some abused women got pregnant to please their partners, while others were forced into abortions against their will.³ In countries where abortion is illegal and unsafe, the procedure puts the woman's life at risk from infection and hemorrhage.

Many women face violence in their relationships from a very early age. In South Africa, "there is a great deal of forced first sex" for adolescent girls, says Katharine Wood of the London School of Hygiene and Tropical Medicine, who has studied this behavior with colleague Dr. Rachel Jewkes.⁴

"Men use coercion or violence to prevent girls from using family planning," she says. Some men oppose contraceptive use, complaining that they believe contraception would make them infertile or would reduce sexual pleasure. Teenage pregnancy commonly results from the combination of sex, violence and refusal to allow use of contraception. Young, single women also face other problems. "Teenagers report being verbally harassed by [family planning] nurses, and they are afraid to go to clinics," Wood says.

For many women, pregnancy does not halt the beatings. Up to 20 percent of pregnant women in the United States and other developed countries report having been abused by their partners, with most studies indicating a range of about 4 to 8 percent. Pregnant adolescents may face an even higher rate of abuse.⁵

Some women are first abused during pregnancy, while for others, the violence is part of an ongoing pattern. Unintended pregnancy may result from violence. An unintended pregnancy may also contribute to violence.⁶ Women who are beaten during pregnancy are more likely to miscarry or have low-birth-weight babies, and they are more likely to postpone prenatal care. Physical abuse may contribute substantially to maternal mortality in some countries.⁷

Fear of violence also leaves many women open to disability or death from STDs. But trying to convince a violent man to use a condom may endanger a woman in a more immediate way. In many cultures, condom use is linked with infidelity, the suspicion of which often triggers domestic violence.

Sexual and physical violence also can lead to pelvic inflammatory disease, chronic pelvic pain, and vaginal bleeding or discharge, which may have no obvious physical cause. Violence also increases the risk of depression, substance abuse, other mental health problems, suicide and murder.⁸

If a woman is beaten, it affects not only her health and well-being, but that of her children. An abused woman is more likely to

beat her children, as is her abusive partner, says Dr. Penn Handwerker, director of the medical anthropology program at the University of Connecticut. The effects on children extend to adulthood. In Barbados, children in households marred by violence were more likely to act out high-risk sexual behavior that can lead to STDs, such as becoming sexually active earlier and having multiple partners during adolescence, according to one study.⁹

"If you experience violence as a child, it sets you on a different path" from children who are not abused, says Dr. Handwerker, the study's author. "An experience of childhood violence is the single best predictor of whether a girl gets pregnant and bears children during adolescence."

SPECIAL CONTRACEPTIVE NEEDS

Abused women clearly have special needs, including medical, psychological and legal support, and safe housing for themselves and their children, according to Kathryn Tolbert of the Population Council in Mexico. "To be effective, solutions must acknowledge the whole problem," she says.

These women also need reproductive health care tailored to their circumstances. "Women need access to emergency contraception and testing for STDs and HIV/AIDS," Tolbert says. "This is true for all women, but especially for those in violent relationships."

"The most important contraceptive service for women in violent relationships is counseling," she says. "Such counseling must include a recognition of the woman's difficulties with her partner and help for her to choose the method that will not make those difficulties worse. Ideally, it will include referral or in-house professional counseling regarding violence issues and the resources available in her community."

Battered women who cannot protect themselves from STDs through condom use may need repeat screening and treatment for STDs. Developing an effective microbicide that could be controlled by women without a partner's knowledge is crucial for their health and safety.

Emergency contraception also is a pressing need for many battered women. To address this need, a Population Council project in Ho Chi Minh City, Vietnam, is surveying calls from abused women to a crisis hotline to find out what reproductive health problems they report. Based on the survey, a curriculum will be developed for hotline workers, which will probably include information on emergency contraception, says Dr. Lynellyn Long, a Population Council country representative in Vietnam.

Women who choose to use family planning methods may face violence, although contraceptive use may be just one of many triggers in a pattern of abusive behavior, rather than the main cause. A recent study in Bolivia through FHI's Women's Studies Project (WSP) found that of 300 women interviewed, 5 percent were physically abused and 15 percent verbally abused by their partners because of their contraceptive use. While women who discontinued oral contraceptive use were no more likely to be beaten than women currently using the pill, there was more partner violence among women who discontinued pill use and did not adopt a new method.¹⁰



AN ILLUSTRATION FROM THE BOOKLET, *MUJER Y ÁMBITO DOMÉSTICO* [WOMEN AND DOMESTIC ENVIRONMENT], PUBLISHED BY CENTRO DE PROMOCIÓN Y CAPACITACIÓN DE LA MUJER (CEPROMU).

A WSP-funded study by the Research Institute for Mindanao Culture in the Philippines found that women who had ever used contraception were more likely to be abused, with more violence linked to longer use.¹¹ And other studies from Mexico, Peru and Kenya report that women are even afraid to bring up the subject of contraception because of possible retribution from their partners.¹²

Because of this fear, a woman may adopt a family planning method in secrecy. "I never told my husband anything" before having an IUD inserted, says Justina, a 32-year-old Bolivian woman with four children. "If he knew, he would beat me worse."

Abused women in Zimbabwe reported hiding their oral contraceptives in bags of maize in the kitchen or burying them in the garden because they were afraid of a partner's violent or otherwise negative reaction.¹³ Other women — including many adolescents in South Africa — opt for injectables, which can easily be used without a partner's knowledge. Requiring a partner's consent before providing contraception may doom victims of violence to further abuse or repeated unwanted pregnancies.

Natural family planning is a poor contraceptive option for women in violent relationships because they cannot rely on their partners to respect the safe period (abstinence during a woman's fertile time). Condoms, because of their requirement for partner cooperation, are not the ideal choice either.

QUALITY CARE

Screening for violence, developing referral networks of legal and other resources, offering treatment tailored to victims' needs, and involving men in family planning programs where it does not compromise women's safety all help provide high-quality care to abused women. In addition, providers may consider documenting evidence of violence in case a woman decides to take legal action.

Despite these deep needs, many providers already are overwhelmed by their other duties, and may be unable or unwilling to intervene.

"For many people who provide family planning services, the system is taxed and resources are short," says McCarragher of FHI. "It is also difficult to talk to women about [violence]. They are afraid to tell, and providers are afraid to ask because of fear of reprisal from husbands."

Still, not addressing violence can lead to ineffective care or put the woman in danger, experts say. And many abused women are willing to discuss their situation, if asked in an attentive, appropriate way.

One of the most important steps providers can take for these women requires simply a shift in attitude — providing a nonjudgmental atmosphere. "If they can do nothing else except ask questions and say, 'This is not your fault,' it can help eliminate self-blame," says Heise of the Center for Health and Gender Equity.

In order to do this, providers need training and education about the problem of domestic violence and possible solutions. Training should be integrated into existing quality of care and family life education programs, not handled as a separate issue, Heise says.

NEW APPROACHES

In Caracas, Venezuela, IPPF is launching a pilot project to train providers in recognizing, treating and referring victims of sexual and physical violence. The three-day intensive training at the Asociación Civil de Planificación Familiar (PLAFAM) will educate physicians, nurses and social workers about the psychological and physical effects of gender-based violence on women's lives.

"A big part of training is making providers comfortable with the topic," says Lynne Stevens, an IPPF consultant directing the effort. "Some have fears about learning about this part of life. For others, it brings up their own family history. And many have been trained to think they have to 'fix' people, but you can not 'fix' survivors of gender-based violence solely with medical interventions," she says.

During the training, staff will learn how to identify victims of violence by asking questions, listening effectively, and observing physical and behavioral symptoms. Researchers have found that a partner's violent behavior often can be detected with a few interview questions, such as: Within the last year, have you been hit, slapped, kicked or otherwise physically hurt by someone?

Within the last year, has anyone forced you to have sexual activities? Are you afraid of your partner (or anyone else you mentioned in previous answers)?¹⁴ With such information, a provider can offer more appropriate counseling on STDs, contraception and pregnancy care, experts say.

The IPPF project will help staff adapt record-keeping to track abused women and offer them special care, including safety assessment and violence education. Stevens is collecting posters, videos and books, so clients can learn about violence themselves while in the clinic waiting room. And staff members are developing a referral network of local agencies.

In other programs, referral has ranged from helping a woman find a safe haven from her partner to directing her to legal assistance, mental health care or abortion services, where possible. To protect privacy, a program in Nicaragua is developing cards with referral information that can be slipped into a woman's bra, Heise says.

In another effort, the United Nations Population Fund (UNFPA) has prepared a guidance note on its role in addressing gender-based violence and its effects on reproductive health. Topics included adding emergency contraception to the method mix, placing materials on violence in public information packages, and training providers on meeting the needs of abused women. UNFPA's Ecuador office is training public-sector health providers in Cuenca to recognize and refer victims of violence.

Educating men and boys, and involving them in reproductive health programs, is an important component of addressing partner violence, experts say. Such programs are rare, but they are beginning to appear. For example, an IPPF affiliate in Jamaica has begun training providers to run men's support groups that discuss gender-based violence. And the French IPPF affiliate is researching men's behavior in order to find ways to better address violence against women.

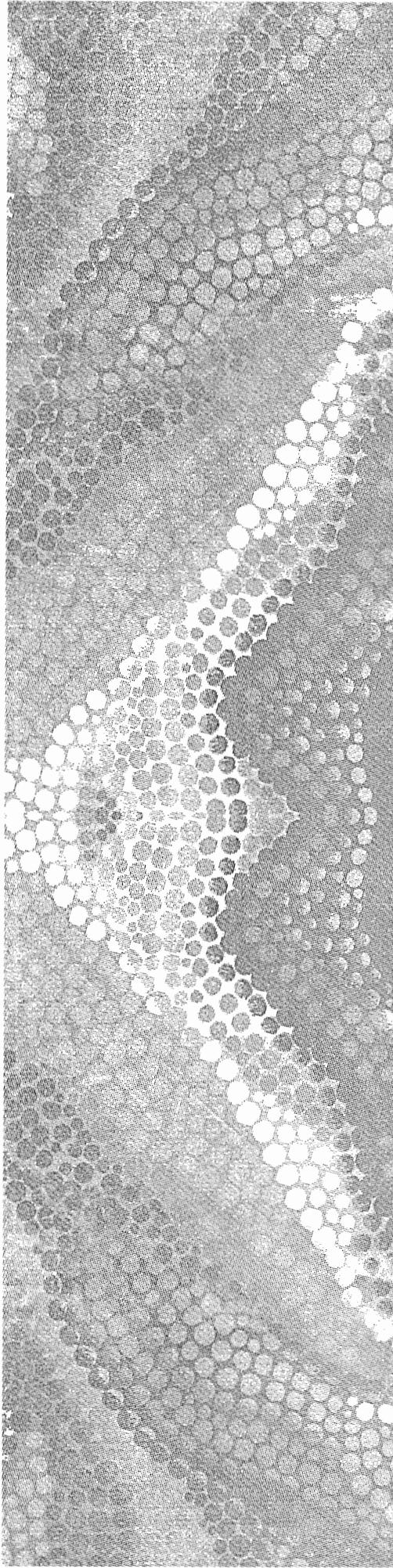
Some family planning programs have even begun offering on-site domestic violence services. For example, the Luxembourg IPPF affiliate offers group therapy and self-defense instruction for victims of violence, and it links women with legal services, says Otoo-Oyortey of IPPF. "Providers are the first point of contact," she says. "They are strategically placed to assist and protect women victims."

Note: Carol Lynn Blaney is a free-lance science writer based in San Jose, CA.

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— Carol Lynn Blaney



Contraception Improves Employment Prospects

Women who work for pay are often expected to handle household chores and childcare.

Women's decisions about having children and pursuing paid employment are seldom made independently of each other. Use of family planning can improve a woman's prospects for employment, which can result in both economic and other personal benefits, including better self-esteem. Family planning can also allow women to seek a better education or additional training, preparing them for better employment or to take part more fully in a range of other desirable activities.

But significant barriers stand in the way of many women benefiting fully from paid work, or ever obtaining work. Furthermore, employed women who have children must handle the stress of juggling employment with childcare arrangements, and often continue to be responsible for household chores.

Studies conducted in 10 countries in Africa, Asia, the Middle East, Latin America and the Caribbean as part of FHI's Women's Studies Project (WSP) illustrate some of these situations in which women commonly find themselves as a result of their family planning and work choices.

WORKING FOR PAY

In several countries, WSP studies show that the use of contraception and resulting decreases in fertility improve the likelihood that a woman will work for pay. This is especially true when women begin contraception

early in their reproductive lives. In Zimbabwe, women who reported contraceptive use at first sex, at marriage and after first birth had significantly fewer children than non-users, and these women were more likely to be currently working.¹

As South Korea's fertility fell dramatically, married women's work participation began to increase. In 1960, Korean mothers with children under the age of six rarely worked outside the home. By 1990, when most married women were rearing only one or two children, 48 percent of mothers with young children were working outside the home.²

Today, Korean women with young children often work, but the demands of caring for young children tend to impede women's employment in other countries. In Cebu, the Philippines, women with infants and preschool children were significantly less likely to be employed outside the home.³ In a WSP collaborative study with Atma Jaya Catholic University conducted in Lampung and South Sumatra, Indonesia, a woman explained: "I could not work in the field when my children were babies. I felt pity for the baby that I held. Once we did not have small children anymore, we could work to our satisfaction. I am as strong as my husband. Man one spade and woman one spade. With family planning we could easily complete our jobs."⁴ In one Zimbabwean study, most men stated that women with

young children should not work away from home. "If children are still young, they need maternal care," said one man.⁵

However, women with small children are more likely to work if they are aided by members of the extended family or have access to day care. In a study in Sri Lanka, the presence of a mother or mother-in-law increased women's labor force participation when they had young children.⁶ In South Korea during the 1970s, employed women with children had difficulty handling their dual responsibilities because rapid industrial growth meant many husbands had to work late hours and could not help in the home. But for Korean women, the burden of working eased with the gradual development of childcare services, sometimes offered by employers.

Family planning not only tends to give women a chance to work, but research in Cebu, the Philippines, indicates that women with small families are more likely to have higher total earnings than women with large families, in part because women with large families tend to work fewer hours. In 1991, women with three or fewer pregnancies worked on average nearly three hours per week more, and earned 54 pesos per week more, than women with four to six pregnancies.

The higher total earnings of women with fewer pregnancies also were attributable to higher hourly wages from work that required more skill and on-the-job training. In contrast, women with more children tended to hold jobs with poor hourly earnings. Women with larger families tend to seek jobs that are flexible, close to home, have shorter work hours and are easy to enter and leave.

Generally, women who had to work to support many children could increase total earnings only by working more hours, which made it more difficult to balance the demands of work and family.⁷ In the Philippines, the same proportion of high-fertility women (defined as having six or more pregnancies) as low-fertility women worked for pay, but the high-fertility group had a lower mean weekly income.⁸

In a WSP study with the University of Indonesia, most working, contraceptive women in Jakarta and Ujung Pandang, Indonesia, said family planning enabled them to work more and with greater efficiency, but few equated family planning with

job advancement.⁹ In Japan, South Korea, Taiwan, Singapore, Thailand and Indonesia — where modern contraception has been widely accepted and family sizes have declined dramatically — the proportion of working women who hold professional, technical and administrative positions has increased in recent decades but remains low. Women tend to work in low-wage jobs in the manufacturing sector, where they experience wage discrimination. In 1989, wages for women employed in manufacturing in Singapore, South Korea and Japan were, respectively, 58 percent, 51 percent and 42 percent of men's wages. In addition, women may be particularly vulnerable to job loss during economic crises.¹⁰

GENDER ROLES

Although family planning is associated with an increased opportunity to work, women who take advantage of this opportunity are still affected by gender roles that define their primary purpose in life as caring for home and family.

Both high- and low-fertility women in such countries as Bangladesh, Indonesia, the Philippines, Egypt and Mali tended to use their earnings not for personal needs but rather for their children's needs and household items. In Indonesia, most working women said their salaries were pooled with their husbands' salaries to meet household needs. Working women in North Sumatra and West Java said they only worked to help their husbands, even when their incomes were greater than their husbands' incomes.¹¹ In Zimbabwe, urban

women reported that the common practice of using women's salaries to buy essentials, while husbands tended to save their own salaries and often spent them on their own relatives, was the most frequent employment-related argument women had with their husbands.¹²

Whether working for pay gives a woman more power to control household finances or make domestic decisions varies widely, as does the association with family harmony. In Northern Mindanao, the Philippines, women were more likely to be abused by their husbands if they worked outside the household, managed child discipline, had help from their husbands with household tasks, or lived in poverty.¹³ In urban North Sumatra, Indonesia, one husband noted, "On the average, my friends who have wives who work, their lives are not

SEAN SPRAGUE/IMPACT VISUALS



WORKING WOMEN ARE OFTEN RESPONSIBLE FOR CHILDCARE OR OTHER FAMILY DUTIES. A BURUNDI WOMAN DOES FARM WORK WHILE TAKING CARE OF HER SLEEPING INFANT.

harmonious, because their wives feel that they can spend money from their own salary, so that they feel they are superior to their husbands.”

In South Korea, where young working women tend to manage both their own earnings and those of their husbands, some couples in a WSP collaborative study felt that a woman’s management of household resources could create tension. One woman commented, however, that “this tension can be eliminated if a couple shares a full trust in each other. There is no need to be conscious about who has a stronger power or authority. It is a matter of responsibility and family well-being rather than a power game.”

In Zimbabwe, women who both work and manage family money often must tell their husbands how they spend money, and husbands tend to determine whether expensive items are purchased. Urban Zimbabwean men thought discussing the household budget with a woman who did not work was easier than with a working woman.¹⁴

Researchers from Central Philippines University in collaboration with WSP found that in Western Visayas, the Philippines, working women were almost twice as likely as non-working women to decide whether or not to travel; they also were more likely to decide for themselves whether to have another child.¹⁵ In Jakarta and Ujung Pandang, Indonesia, in-depth interviews of couples showed that husbands tended to dominate decision-making about matters such as a wife’s travel outside the community, children’s schooling or having another child, even when their wives were employed. Some women, however, do make their own decisions. Said one working woman from this study who had used family planning, “I am free to decide. My husband never forbids me to do anything, like going out of the city with friends or choosing which school my children go to.”

SHARING DOMESTIC TASKS

Almost without exception, women around the world report difficulty in balancing work and family responsibilities.

In China, Indonesia, the Philippines and South Korea, women are primarily responsible for domestic work. Cooking was the woman’s responsibility 90 percent of the time in Jakarta, Indonesia, and 83 percent of

UNICEF/5745/LAUREN GOODSMITH



IN MAURITANIA, A WOMAN WORKS WITH A COMPUTER.

the time in Ujung Pandang, Indonesia. Childcare was the woman’s task 87 percent of the time in Jakarta and 71 percent of the time in Ujung Pandang.

In developing countries, household tasks are often performed without modern conveniences, such as running water, appliances, gas or oil heat. Furthermore, women often are expected to serve in-laws and are likely to be responsible for the care of both their own and their husband’s elderly parents.

Some of this burden would be eased if husbands shared more domestic tasks. But a 1986 survey in Japan showed that married women with paying jobs spent an average of two hours and 26 minutes a day on household chores, while married men spent very little time, an average of seven minutes.¹⁶ In the South Korean study, young working women reported that they would like to share household work with men, but often found men unenthusiastic about the idea. One woman explained why, after only a few months of marriage, she resigned herself to assuming nearly all household responsibilities: “I was fed up with having to tell him every detail of housework and to repeat it every day.” In focus group discussions, young working Korean women said their husbands and other relatives helped with childcare, yet childcare remained their responsibility and the sharing of domestic tasks caused constant friction with husbands and in-laws.

In Zimbabwe, men approved of their wives working, but thought a woman’s first priority should be domestic responsibilities. Again, the domestic burden placed on women depended greatly on husbands’ attitudes. In Jakarta, Indonesia, the husband of a working woman who used contraception observed that “women are more tired than men. They look after children, wash clothes and dishes, prepare meals for us and the children. We just appreciate what they have done for us. I realize that, so I help her by washing the dishes.”

Women’s specific concerns about fulfilling both work and family demands vary from one culture to another. But women, in general, feel ambivalent about their dual roles and worry about how to ration their time and energy. In Egypt, for example, a study of women who worked in family planning programs revealed that the women generally were proud of, and satisfied with, their jobs and experienced greater autonomy in their homes. Yet, they said they lacked time both for their families and personal needs.¹⁷

Working women said competing demands on their time caused them to function unsatisfactorily at home and at work. In the South Korea study, working wives reported feeling incompetent in housework, especially

cooking, compared to older housewives. They also reported they felt they had to choose between children and work.

Other young, working Korean women regretted not having enough time to spend with their babies and worried when others cared for their sick children. In Central Java, Indonesia, rural women often worked, but were judged neglectful if they didn't care for their sick children.¹⁸ In the FHI-sponsored survey of 800 women in Lampung and South Sumatra, Indonesia, working women felt better able to meet the economic needs of their families, but expressed lower satisfaction with their family's welfare and felt they lacked time for themselves and others.

Because working may give women new skills and enhance leadership qualities, working women may be better prepared for, and take more interest in, civic activities. However, other time-consuming responsibilities, as well as constraints associated with community or gender norms, can prevent women from using such opportunities. In Zimbabwe, despite greater contraceptive use and education, women participate little in community activities, due in part to societal norms. In focus group discussions, Zimbabwean women with five or more children unanimously agreed that men generally thought women's involvement in community activities, such as knitting or sewing clubs, gave women an opportunity to engage in prostitution, just as Zimbabwean women are often suspected of engaging in extramarital affairs if they work.¹⁹

In South Korea, most women today are relatively free by their early 30s to participate in activities outside the home. However, women's participation in politics is among the lowest in the world. South Korea's strong patriarchal family tradition discourages women from political activity. Instead, younger working women, from both middle and upper classes, spend most of their free time taking care of their families and homes. In Egypt, women who were employed in family planning reported that the demands of work and family left them little time for participation in community activities.

DECIDING NOT TO WORK

Many factors influence a woman's decision whether or not to work for pay. A woman using family planning may not be able to take advantage of work opportunities because she is illiterate, unable to speak the country's dominant language, or lacks marketable skills, training opportunities, transportation or childcare. In Zimbabwe, women wanted to work, but only 32 percent did so outside the home, in part because job opportunities for both women and men were limited.²⁰

Some family planning users are unable to work because their husbands or other family members prohibit it. In Mali, the husband's family generally did not oppose a woman's working, but most women needed their husband's permission to do so.²¹ "If the husband says it's okay to go to work, yes, she may," said a woman from North Sumatra, Indonesia. "But if he says no, don't go, then she better not go." Ninety-one percent of women in Jakarta, Indonesia, and 58 percent in Ujung Pandang who had ever worked said they had asked their husbands if they could start or continue working.

Some experts speculate that some women using family planning may feel unable to work because of contraceptive side effects, although there is little research on the topic. Headaches, dizziness and irregular menstrual bleeding associated with some methods could affect women's ability to work.

If household finances permit, many women prefer not to do paid work even if they have the opportunity. Not working, they feel, is better for the family. Women in the FHI studies valued motherhood as an important — and often the most important — role in their lives. For many, it represented the pinnacle of personal fulfillment.

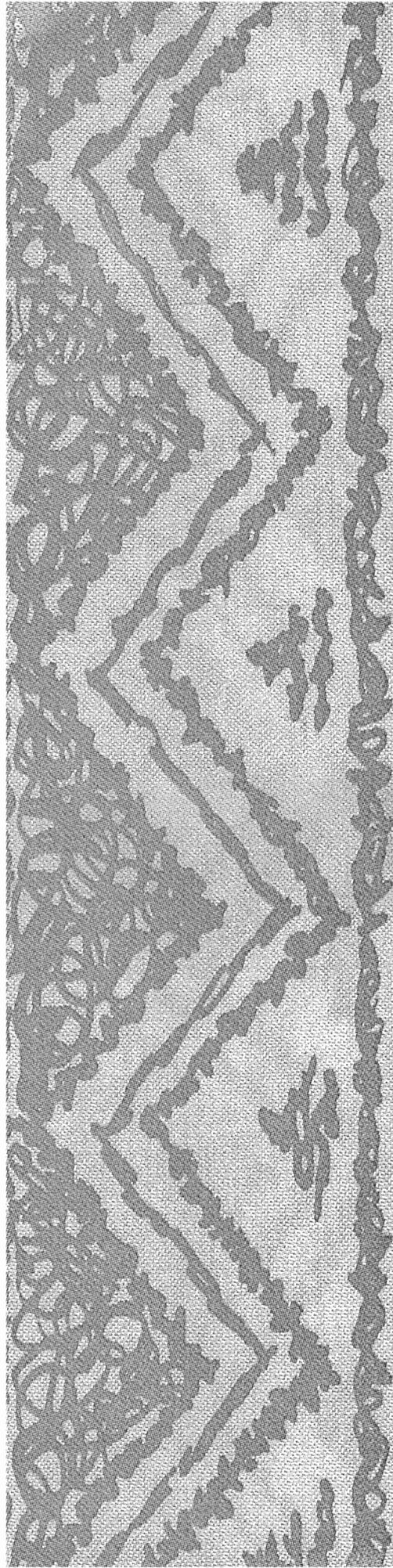
Many women simply did not value the autonomy and empowerment that participation in the paid labor force might provide. "It is good if [a man] is capable of fulfilling the basic needs — clothing, food and housing," said a woman from urban West Java, Indonesia. "That's why if he has satisfied all that, it is nicer to stay at home. Actually, working is tiring, isn't it?"

— Kim Best

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What People Want From Services

Interest in contraceptive side effects suggests an important role for counseling.

In family planning programs, there can be gaps between the services offered and the services clients need. A better understanding of what women and men want from family planning programs can help bridge these gaps. Studies by FHI's Women's Studies Project (WSP) show that clients have clear ideas about what they want from reproductive health programs. For example, clients want explicit information about contraceptive method side effects. In addition, they want services for men.

The studies also show that people seek a comfortable environment for discussing their private health-care needs. Clients want programs that focus on quality, which includes a variety of contraceptive choices, thorough counseling from knowledgeable and skillful providers, and privacy during counseling and examinations. Above all, women and men say they want to be treated with dignity and respect.

Designing services with an awareness of gender, the roles prescribed by society for women and men, can help programs achieve some of these important expectations.

"I prefer to go there, even though it is far away, because they treat me kindly," said a woman from El Alto, Bolivia, describing a distant clinic she attends. "They talk to me, they explain things — everything. And when I do not understand or do not 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."¹

SIDE EFFECTS

Clients are especially concerned about contraceptive side effects. While providers may downplay side effects because they are not life-threatening, clients say side effects do alter their daily lives. Real or perceived, side effects are the reason many couples stop or refuse to use contraception. WSP research found that side effects were a major concern for women and men.

In a WSP study in Zimbabwe, women and men said family planning was an important element in quality of life. However, women also identified negative consequences of family planning — method failure, headaches, and prolonged menstrual bleeding. They asked that health providers offer more information on methods and that men be included in counseling. "The couple can then decide together on how they can solve the problems," one man said. "They may choose to use traditional methods of birth spacing or agree that the husband uses a condom."²

In Indonesia, 31 percent of the 180 contraceptive users in South Sumatra and Lampung reported what they considered to be "major" problems related to contraceptive use. These included weight gain or loss, headache, amenorrhea, irregular menstrual bleeding and fatigue. One woman in Lampung said that oral contraceptives caused numerous difficulties, including loss of sexual desire.³

Another Indonesian woman, a 44-year-old mother of four, said she was unhappy with the "safari system" of family planning,

in which health workers visit a village to provide methods, but leave shortly thereafter, unavailable to counsel women about side effects. "The acceptor had to take the risk" without readily available help, she said. "Protest? This is a village. It is not polite to protest."⁴

In Iloilo, the Philippines, efficacy and freedom from side effects were the first and second most important factors identified by 1,100 women regarding their use of family planning. When users were asked why they wanted to continue their current method, nearly one-fourth cited freedom from side effects. When people who do not use family planning were asked why they would be willing to select a particular method in the future, 12 percent said freedom from side effects was important.⁵

A study conducted by the Research Institute for Mindanao Culture (RIMCU) in the Philippines, with assistance from the Population Council, surveyed 400 married women who began using contraception in 1992 and found a dropout rate of 31 percent in public/government programs in the first year. More than half the dropouts said they discontinued because of side effects. Seventy-one percent of the 96 pill users cited side effects as the reason for abandoning their method.⁶

In Bangladesh, 40 percent of 104 women interviewed said they had experienced health problems from contraceptive use. For many, side effects brought physical discomfort as well as emotional distress when husbands became concerned about women's inability to work or the costs of treating side effects. "My husband became very angry and scolded me a lot when I became sick from using the Copper-T. He told me, 'I will not take care of you if anything happens, nor will I provide you with treatment.'"⁷

For some people, fear of side effects discourages them from starting family planning. In Cebu, the Philippines, nearly 40 percent of 296 non-contraceptives users in a WSP

study said they were concerned about side effects.⁸ In addition, many women and men base their decisions not to use family planning on incorrect or misleading information. For some users, even those who received counseling, the reality of side effects is difficult to accept. Said a woman in Mali who experienced amenorrhea, "Even though they told me ... I would go all this time without seeing my period ... well, I wasn't really expecting that."⁹

Thorough counseling can help clients determine which symptoms are caused by contraception and which signal other health concerns. WSP scientists have recommended that providers receive special training in how to manage side effects — for example, recommending ibuprofen or estrogen to curb heavy menstrual bleeding. The scientists also recommended that health providers work with women's advocates to establish peer networks, in which experienced users could counsel new users about potential side effects and practical strategies for coping with them. Research to develop methods that have fewer side effects is also important. "We should not be satisfied with women having to decide which side effects they will choose," said Edna Roland of FALA PRETA! [Speak, black women!] in Brazil, a women's health advocacy group.

INVOLVING MEN

In many cultures, contraceptive use is viewed as women's responsibility. Yet, decisions about family size and family planning are seen as men's responsibility. A study of 711 men in Zimbabwe found that 39 percent thought men should make family planning decisions and 54 percent thought men should prevail in decisions about family size; however, 60 percent thought women should assume responsibility for obtaining contraceptive methods.¹⁰ Even though men are often the chief decision-makers, they receive little, if any, counseling that would enable them to make informed choices or help their wives make choices about contraceptive use.

"When family planning started, it was integrated with maternal-child health," says Dr. Firman Lubis of Yayasan Kusuma Buana (YKB), a family planning organization that provides services and conducts research in Indonesia. "One of the disadvantages when we started is that family planning focused on women and contraception. We really need to change programs to focus on men and fit the men's situation."

Men say they want more information about male methods and side effects, about female methods and side effects, and about access to services. In a "mystery client" survey in Kenya, where men posed as clients to

help evaluate services, the men were treated with courtesy and promptly received private counseling about vasectomy. However, there were no educational materials for men and the female providers were uncomfortable talking to them.¹¹

In China, WSP research funded by the Rockefeller Foundation found that a majority of people surveyed said male contraceptive services were available at local family planning clinics. Nonetheless, men did not routinely seek contraceptive services. One 40-year-old man from South Jiangsu explained that male methods are less popular because "males take less

DR. CYNTHIA WASZAK/FHI



EGYPTIAN FAMILY PLANNING PROVIDERS.

responsibility for family planning. They have primary responsibility for physical labor. ... Publicity for family planning always targets females."¹²

Women in Jakarta and Ujung Pandang, Indonesia, were asked how family planning services could involve men. Their suggestions included: more information and counseling; more advertising about men's methods; information provided through the work place; and more services and male methods. They also mentioned special clinic hours to accommodate men and strategies to make men more comfortable.

Not all women want men to participate in family planning. The same study found that 39 percent of women in Jakarta and 11 percent in Ujung Pandang would rather not have men involved in family planning programs.¹³

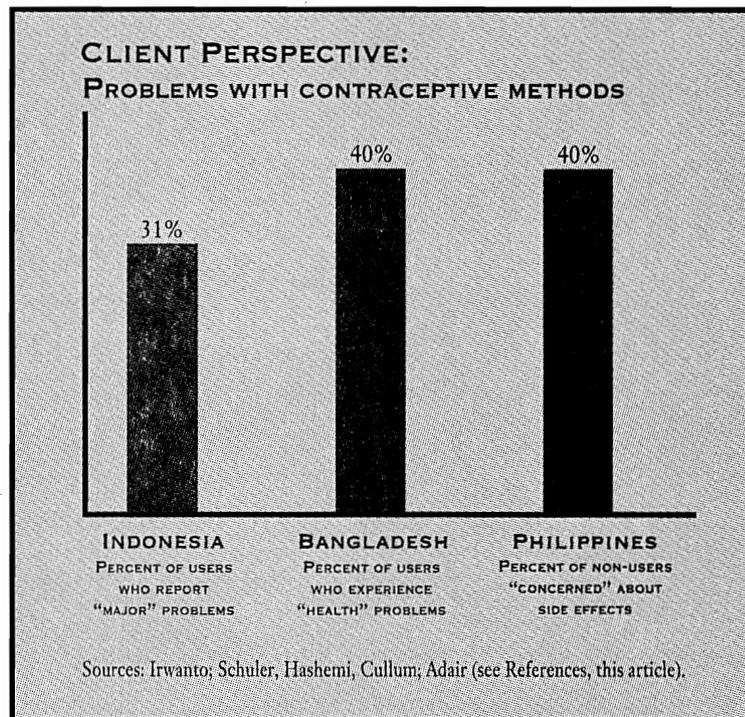
GENDER SENSITIVITY

In order to serve both women and men better, providers should consider ways to make programs more "gender-sensitive" — to consider how roles prescribed by society affect men and women differently in terms of health needs, access to information and access to services.

In Bolivia, WSP is developing guidelines to help understand how gender roles affect family planning services. Based on a thorough examination at several clinics, a committee of health professionals, activists, women's advocates and researchers will share ideas about how to make programs more gender-sensitive, by developing a manual providers can use to incorporate gender awareness into their programs.

For example, many women interviewed in Bolivia said they did not discuss contraceptive use with husbands because they were too shy. The reluctance was multiplied when they confronted a health provider — who was often a stranger and a male.

The same gender norms that encourage women to be submissive and silent with their husbands, and norms that equate female



sexual knowledge with promiscuity, also affect women's ability to talk openly with male health providers about intimate sexual issues. For some women, reproductive health services offered by men are unacceptable.

Women in Jakarta and Ujung Pandang, Indonesia, said they would not accept certain services from male health providers. For example, about 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, diagnoses for a sexually transmitted disease, or injections in the buttocks. More than half the 500 women interviewed suggested clinics hire more female providers.

In Egypt, many women participating in a study on quality of care refused services from male providers, citing Islamic religious traditions as their reason. "The most important thing for me in the examination is to have a female doctor," said one older Egyptian woman. "I went once to the clinic to insert an IUD. I paid the money and waited and when it was my turn, I entered the examination room and there stood a male doctor. I refused the IUD insertion, of course. I left the money I paid and returned back home. Later on I got pregnant."¹⁴

Egyptian men cited a female doctor as the most important element of quality of care for their wives. "Especially in the gynecological diseases, the woman likes the doctor in front of her to be a female, in order to have the same feelings, as this is very important to feel the same pain — which is different if the doctor is male ... so he will not feel the same importance, and his diagnosis will not be 100 percent correct," said one husband.

In both Egypt and Indonesia, FHI researchers recommended the addition of female doctors to family planning programs. But that is not always an easy task. Gender norms often restrict women's access to the education and training neces-

sary to work, restrict movement outside the home or community, and delegate primary childcare and housework responsibilities to women, even if they earn income.

A WSP study in Egypt found that 82 percent of the nation's 19,610 family planning employees are women. However, only 48 percent of physicians are female. For the Ministry of Health and Population, the country's largest provider of family planning services, only 27 percent of gynecologists are women.¹⁵

The presence of female providers does not guarantee better service, nor does it promote gender equity. In Bangladesh, the national family planning program has employed nearly 30,000 female health workers nationwide to provide contraceptive services to women in their homes, accommodating *pardah*, which requires women to be secluded in their homes or villages. However, some researchers have concluded that, despite the advantage of greater accessibility, this system may actually reinforce women's subordination and isolation. They suggested that freestanding clinics might encourage women to venture outside their homes and provide them with a broader array of health-care services, especially treatment for side effects.¹⁶

WHAT IS A "GENDER-SENSITIVE" PROGRAM?

CHRIS STOWERS/PANOS PICTURES



A COUPLE VISITS A FAMILY PLANNING CLINIC IN THE PHILIPPINES.

A panel of international experts from many organizations, formed by the U.S. Agency for International Development (USAID), recently defined "gender-sensitive" reproductive health programs as those that "actively involve women and men in prioritizing their own reproductive health needs, concerns and reproductive health intentions."

According to the USAID Gender Working Group's subcommittee on program implementation, there are many specific features of a "gender-sensitive" program, including the following. Such programs:

- Involve women in identifying, prioritizing and resolving their own reproductive health needs.
- Involve women's partners and promote male responsibilities.
- Empower women to change their status within the home and the community — through income generation, literacy and political participation.
- Address social, economic and physical barriers to access for women and men.
- Address domestic violence, emotional and physical abuse, and the threat of abandonment.
- Provide a broad range of services and interventions to women and men's reproductive needs and intentions.
- In designing programs, allow time for participatory process to hear community needs.
- Focus on clients' reproductive health needs, instead of demographic goals only.
- Address sexual health and needs for sex education.
- Include women at the policy-making level.
- Pursue the framework outlined at the 1994 International Population and Development Conference in Cairo and the 1995 Fourth World Conference on Women in Beijing.
- Recognize how gender affects male/female relationships and existing inequities.

— Barbara Barnett

Gender is not the only factor that creates an imbalance of power between client and provider. Class, race, ethnicity, age, education — all can influence provider-client communications. "An imbalance of power exists between provider and client," says Dr. Aníbal Faúndes of the State University of Campinas in Brazil. "This can be true of female providers as well. The provider is the one who decides what information to give, which methods are indicated or contraindicated, when and how to treat side effects, and even the number of patients to attend to on any given day. Gender is only one factor that affects the balance of power between client and provider."

In Bolivia, for example, women who wore the *pollera*, the traditional female dress of the Altiplano, said they experienced discrimination when they sought care from providers in urban El Alto.

CLIENT SATISFACTION

Clients want quality services and providers strive to offer quality. However, definitions of quality can differ.

In El Alto, Bolivia, WSP researchers explored three aspects of service quality: interpersonal relationships between clients and providers; availability of contraceptive methods; and acceptability of services from the perspectives of 217 clients, 85 providers and 215 non-clients.¹⁷ Findings show that clients and providers often had different points of view.

While nearly all providers said they explained procedures before physical exams, only about 70 percent of clients said they received explanations. In addition, contraceptive supplies were often limited. Fifteen of 36 health centers surveyed had no reversible methods in stock.

Researchers recommended that health centers increase access to contraceptive methods, that providers receive training to improve their interactions with clients and that providers receive training to update their clinical skills and medical knowledge. In addition, researchers recommended that providers

counsel clients in private so that women and men would feel more comfortable asking questions.

In a Population Council study in Kenya, clients said counseling about side effects and method choice was a major element of quality services, as were costs and access. Clients said they were dissatisfied when they received information about only one method or a limited number of methods. Ironically, when questioned about quality, providers did not mention counseling as an issue.¹⁸

While WSP found that most family planning clients say they are satisfied with services, these clients also have suggestions for improvements.

In Indonesia, where government family planning has been widely available since the 1970s, women say contraception has helped them improve the quality of their lives, brought peace and harmony at home and helped them be more efficient at work, in addition to helping them earn more money. However, while women have access to methods, they often want more information.

In South Sumatra and Lampung, 69 percent of the nearly 600 women interviewed said they were satisfied with their most recent family planning methods.¹⁹ However, when asked if they received enough information, some women said no.

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

Lack of information was a concern expressed by women in the Egypt quality of care study.²¹ One young family planning client explained her reluctance to

try Norplant. "They say that the capsules are put under the skin — no one knows what it does — so a woman can have it placed but she would not know what could happen to her."

Clients in the Egyptian study also said that other important elements of quality are that providers treat them with respect, regardless of education or income; that family planning services be integrated with other health services; that services be affordable and accessible; and that they have a choice of methods.

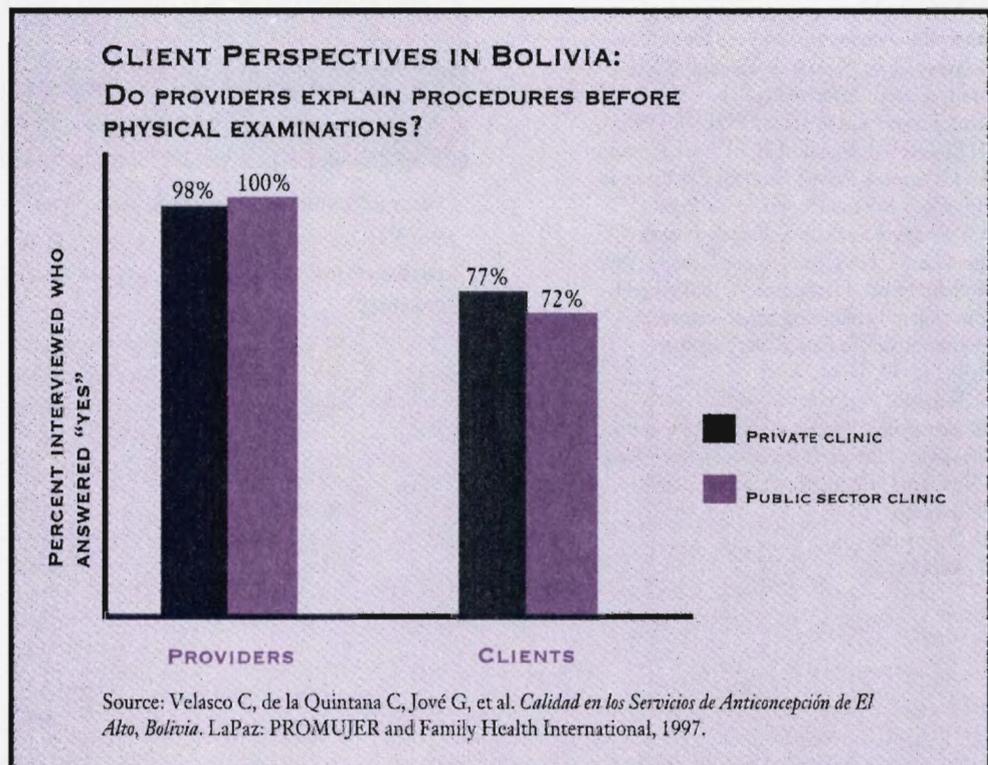
"The important thing," said one female study participant, "is for the doctor to sit down and discuss with the woman what suits her, and not just to tell the woman right after examining her that she needs an IUD. The doctor should discuss [methods] with the patient. The doctor should consider the method the woman feels comfortable with."

Another Egyptian woman, who does not use family planning services, expressed her needs more simply. "I want to be treated as a human being," she said. Providers should "not recoil from us."

— Barbara Barnett

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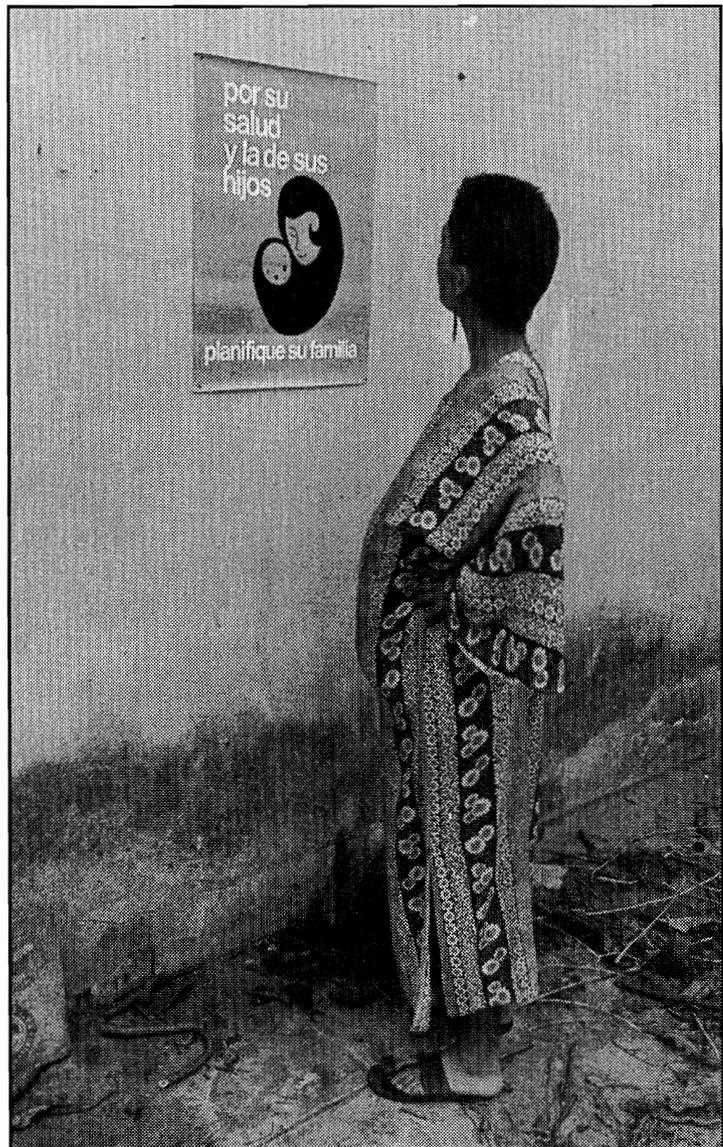
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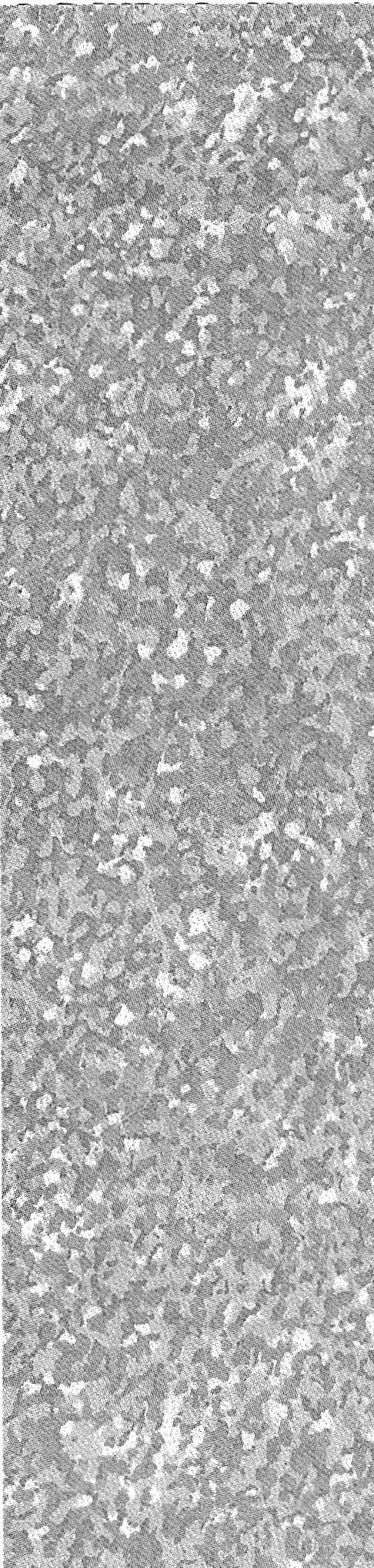
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FAMILY PLANNING SERVICES TYPICALLY FOCUS ON WOMEN. INVOLVING MEN WOULD ALLOW COUPLES TO MAKE BETTER-INFORMED CHOICES ABOUT CONTRACEPTION. A CUBAN WOMAN LOOKS AT A POSTER ABOUT FAMILY PLANNING.



Expanding Beyond “Mother-Child” Services

Bolivian studies indicate how male involvement and other “gender awareness” steps can improve services.

Throughout South America, serving the “mother with child” client has been the foundation of many reproductive health policies and projects. But this focus may exclude many people who need services, such as childless women, women who have completed childbearing and men. Moreover, “mother-father” and “mother-doctor” relationships are also vitally important for reproductive health.

Studies by FHI’s Women’s Studies Project in Bolivia highlight the need to explore multiple relationships in the reproductive health arena, rather than focusing on women alone or on women and their children.

A survey of 630 couples in Cochabamba, Bolivia, sought to understand family dynamics surrounding reproductive health by examining the relationship between men’s knowledge and attitudes concerning fertility control and their wives’ use of contraceptives.¹

Study results showed that men knew slightly more than women about different contraceptive methods. Men generally approved of contraceptive use and reported a willingness to use a contraceptive method or support their partners’ use of methods. However, only half the men reported having talked with their wives about family size. For a significant proportion of couples, both partners did not agree on what method was being used: Among couples in which at least one partner claimed the couple was using the rhythm method, in only two out of three couples did both partners report using this method.

Attempts to reach beyond women clients to the men in their lives include innovative reproductive health services provided by La Casa de la Mujer (The Women’s House) in Santa Cruz, Bolivia. La Casa was organized by women to empower women, but participants gradually discovered that focusing on women exclusively rarely solved women’s problems and, in some cases, created new difficulties for them.

“When the man does not participate, problems arise,” explains Ane Mie van Dyke, a La Casa nurse. “A woman learns something new that the husband doesn’t understand, and he does not like to feel stupid in front of his wife.” When one client refused sexual relations in order to adhere to the rhythm method of contraception, her partner hit her and forced her to have sex. When she became pregnant, he hit her again. Another client’s husband accused her of being unfaithful when she brought home condoms in an effort to space births.²

“We’ve seen that working only with women doesn’t solve the problems,” says La Casa gynecologist Dr. Lourdes Uriona. “In terms of family dynamics, reproductive health needs to involve both partners. In medical terms, as well, men need to participate. In the case of sexually transmitted infections, if the man isn’t treated at the same time as the woman, our efforts are in vain.”

La Casa’s efforts to involve men in education and services include conducting family planning workshops for couples, working

with young men and women, and attempting to incorporate partners of female clients in center activities.

HEALTH PROFESSIONALS

Gender awareness not only helps couples to analyze and improve their relationships, but enhances relationships between clients and health professionals as well.

An FHI study of the Center for Research and Development of Women (CIDEM)'s health center in El Alto, Bolivia, focused on the center's efforts to empower local women. CIDEM has enabled and encouraged participants to make decisions about their own reproductive health, and to help design health policies and projects. These efforts were challenged, however, when women who had learned to demand respect and to take responsibility for their own health encountered professionals unwilling to share greater knowledge and decision-making.³ Other researchers in El Alto found that many women believe providers are not informing them about alternative method choices or side effects of each method, or not allowing them to take part in decisions about the need for cesarean sections and other medical procedures. They concluded that the tendency of clinic doctors and staff to dismiss clients' questions and concerns about contraceptive methods undermined the providers' ability to counter misinformation and relieve women's fears.⁴

CIDEM questioned the established practice of medical professionals making important diagnoses and treatment decisions with little input from patients. The organization developed an approach in which providers and clients discuss options in a collaborative manner. Professionals learned to respect clients, listen to them, and speak their language, both literally and figuratively, in ongoing relationships characterized by a sharing of knowledge, as well as power, over reproductive health issues. This approach has led to increased provider-client cooperation, more accurate diagnoses and improved client health.

CIDEM encouraged the use of this model of client-provider decision-making by referring its childbirth patients to clinics where medical personnel participated in CIDEM-facilitated workshops and made a commitment to such practices. Women who

have received care in participating centers indicate that treatment has improved substantially. Celia Pérez, a young mother of two from El Alto, contrasted the care she experienced during her first childbirth to the positive attention she received during her second delivery: "Many women, especially those in traditional dress, accept abuse from doctors because they think doctors are superior. With CIDEM, I learned that they have no right to treat me like that. The second time I went to give birth, I told the doctor, 'I am going to cooperate with you, and I want you to cooperate with me,' and it was much better."

BODY AND MIND

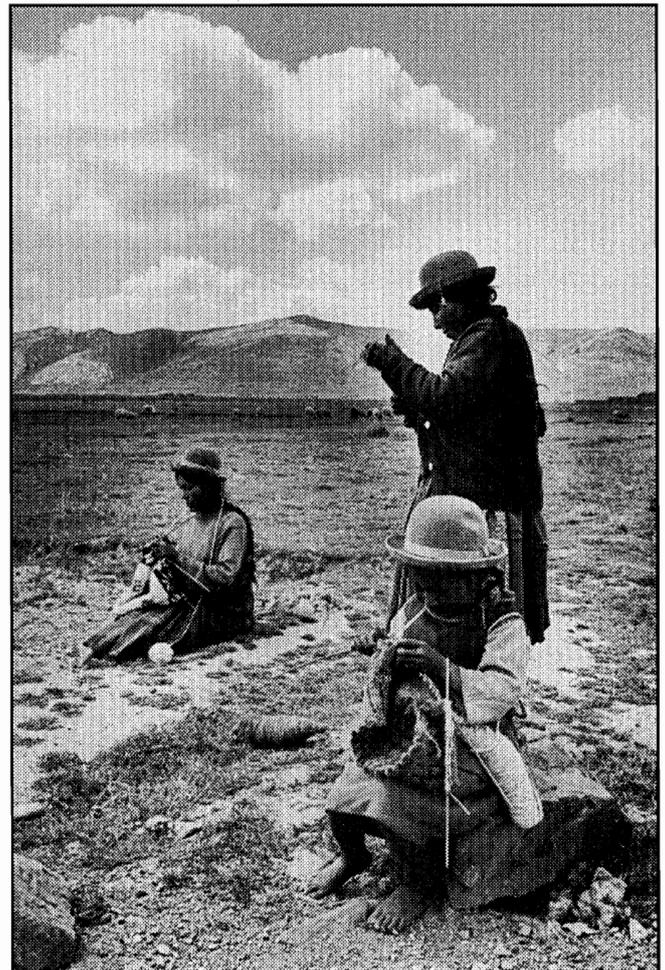
Sexual biology influences the development of cultural roles and relationships in complex ways. That women bear and nurse children, for example, is a fundamental factor in the development of gender identities and symbols, although these identities vary tremendously across cultures and through time.

Likewise, gender practices affect women's physiological development and functioning. Tight corsets, foot binding and female genital mutilation are just a few practices that harm women's health and sexuality. While the use of modern contraceptives has many important benefits, methods can sometimes produce undesirable side effects. As such, they can affect women physiologically.

Psychological factors also play a role. Dr. Uriona of La Casa believes that shame, fear and guilt can harm her clients' health. A repressive social environment, she says, dis-

courages open conversations to help resolve psychological and physical problems. "The stress and oppression that women experience in their lives are often manifested in physical problems, especially gynecological problems," she says. Most of this pain is rooted in her patients' inability to express their feelings and needs. "For some women, shame and repressed emotions interfere with the ability to feel pleasure or pain in the genital area," she says. "This condition not only harms marital relations but interferes with medical diagnosis."

BERYL GOLDBERG



RURAL WOMEN, WHO TYPICALLY WEAR TRADITIONAL DRESS, SAY THEY EXPERIENCE DISCRIMINATION WHEN SEEKING CARE IN CITY CLINICS. THESE RURAL BOLIVIAN WOMEN AND GIRL KNIT AS THEY WATCH OVER SHEEP.

That feelings of shame can notably reduce women's sexual pleasure was one conclusion from a study involving focus group discussions and in-depth interviews with 132 women and men in El Alto, Bolivia. When

asked the question: "Do you let your partner know what you do or do not like during sexual relations?" men reported with much more frequency than women that they told their partners what they liked. When asked whether they enjoy sexual relations, a majority of men affirmed that they enjoy sex, while a majority of women said they do not.⁵

For many women in this and other studies conducted in Bolivia, shame was coupled with fear about reproductive events such as menstruation, miscarriage and disease, as well as fear and mistrust of contraceptive technology. Researchers found that fear of contraceptives produces psychosomatic problems related to method use, high rates of discontinuation of pills and injections, and early removal of intrauterine devices (IUDs).⁶

Client-oriented providers help combat the negative effects of shame and fear commonly associated with sex and reproductive health care by listening closely to what clients say and respecting their feelings. "We begin every consultation with an open conversation in which the patient has the opportunity to express her problems in narrative form," says Dr. Uriona. "We often talk in the native language Quechua, the patient tells me about her life, and I thus begin to get a glimpse of where tensions arise."

In order to improve the population's health in sustainable ways, however, gender-sensitive services must be complemented by structural changes in educational, legal, religious and other institutions that generate and reinforce shame, fear and misinformation, hindering sound reproductive health.

RECOGNIZING DIFFERENCES

A gender perspective also helps providers recognize and respond to crucial differences among clients. Two kinds of gender differentiation have been identified in Bolivia. The first involves qualitative differences in the lifestyles and experiences of groups distinguished by their sexual identities, such as wife/mother, single professional mother, or male homosexual. The second involves sexual discrimination in legal, political, religious, educational and economic institutions, where policies and practices tend to transform gender differences into inequalities.

CIDEM's and La Casa's health centers try to take into account the differing practices, expectations and needs of the gender groups they serve, which include market women, male adolescents, prostitutes, rural Indians and middle-class housewives. La Casa staff's awareness of the difficulties inherent in educating and providing services to people with perspectives and experiences different from their own has motivated them to experiment with innovative approaches to learning and communication, such as theater, art and games. A key benefit of these approaches is that they help equalize the balance of power between providers and clients.

Numerous reproductive health programs in Bolivia have attempted to reduce institutionalized gender inequalities through efforts ranging from consciousness-raising courses to advocating national legal reforms, such as recent legislation against domestic violence.

Recognizing that health programs often fail to provide equitable access and care to all clients, CIDEM took steps to make its services more accessible to women who have childcare responsibilities, have limitations on mobility and money, or who fear mistreatment and humiliation. It offered low prices and services located on a bus route in a working-class neighborhood, and treated poor and indigenous women with respect. CIDEM personnel avoid sexist or racist language as part of the effort to develop more equitable relationships, both between providers and clients and among staff members.

Reproductive health and reproductive rights extend beyond family planning. From a gender perspective, women and men are not just reproductive beings, but multifaceted individuals with complex concerns, needs and expectations, all of which are influenced by their gender roles and relationships, developed in specific cultural contexts.

A major concern for most Bolivians is economic survival. Families must seriously consider whether or not they will be able to feed more children. For many women, recent economic crises have meant having to diversify wage-earning activities and increase work hours. As these women wash clothes, sell goods in the market, grow potatoes or perform other paying work, they also bear and raise children and engage in a range of family and social activities. These

heavy labor burdens limit access to health care and fertility control services. As a young woman who came to CIDEM for legal advice explained, "I have four children and I have to work. There simply isn't time to go to the clinic, even though there is one near my house."⁷

Often, larger issues like economic and food security, legal and political rights, and access to education and information strongly affect sexual and reproductive health. Clearly, providers cannot remedy such problems by themselves. However, a gender perspective can help them to recognize attitudes that govern and shape reproductive health behaviors; identify barriers to reproductive health care; explore new strategies to improve services for women and men; and develop referral programs and collaborative efforts with other organizations to improve the conditions under which different members of the population exercise their rights to sexual and reproductive health.

—Susan Paulson, PhD

Note: Dr. Paulson, an anthropologist who lives in Brazil, has conducted research about gender issues and has taught at several Latin American schools and universities.

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Gender Insights Can Improve Services

By Susan Paulson, PhD

Gender beliefs and practices define roles, opportunities and limitations for women and men, greatly influencing life in all societies. Aspects of daily life shaped by gender include use of language and means of self-expression, dress and appearance, education, work opportunities, family structure and size, and each individual's health.

Practical experiences with gender issues in reproductive health services have led to several basic observations, which provide useful insights into ways to improve services and policies.

- Women and men experience sexuality and reproductive health differently, in ways that are shaped by their ethnic, cultural and class groups, as well as by their sexual identities. Providers can improve care by responding to these different identities and perceptions.

- Reproductive health services that broaden their scope to include men's reproductive health, men's and women's relationships, and women's relationships with others tend to be more successful than those that focus exclusively on women.

- Men and women's reproductive health is influenced by religion, politics, economic conditions, the environment and education. Reproductive health policies and services need to take into account this larger context.

A gender perspective allows providers to go beyond focusing on women to view reproductive health as family health and as a social issue. It addresses the dynamics of knowledge, power and decision-making in sexual relationships, between providers and clients, and between community or political leaders and citizens.

Research conducted throughout the world shows that working only with women to improve reproductive health is inadequate. Often, women's relationships with their husbands, mothers-in-law, religious authorities or others prohibit them from acquiring or using knowledge, or obtaining contraceptive methods that offer protection against pregnancy and sexually transmitted diseases, including HIV.

A gender perspective must go beyond health services to promote sustainable improvements in reproductive health. This perspective can be used to analyze and promote beneficial changes in a variety of social, political and educational settings, leading to more inclusive and equitable practices in communities, organizations and institutions.

Note: Dr. Paulson is an anthropologist who has taught gender studies at Centro de Estudios Superiores Universitarios in Cochabamba, Bolivia, and at Colegio Andino in Cuzco, Peru.

CARLOS CONDE/INTER-AMERICAN DEVELOPMENT BANK



MANY ASPECTS OF DAILY LIFE ARE SHAPED BY GENDER BELIEFS.

Quality of Life

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Contraceptive needs after age 40. Blaney CL. 1997 Fall;18(1):4-7.

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Oral contraceptives

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Condom use increasing. Finger WR. 1998 Spring; 18(3):20-23.

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STDs

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Men's reproductive health risks. Best K. 1998 Spring;18(3):7-10.

Sterilization (female and male)

Attracting men to vasectomy. Finger WR. 1998 Spring;18(3):26-27, 32.

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Vasectomy - see Sterilization (female and male)

Violence

Abused women have special needs. Blaney CL. 1998 Summer;18(4):15-18.

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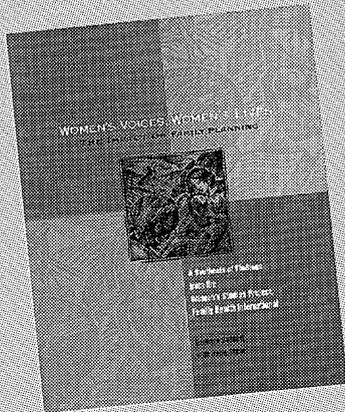
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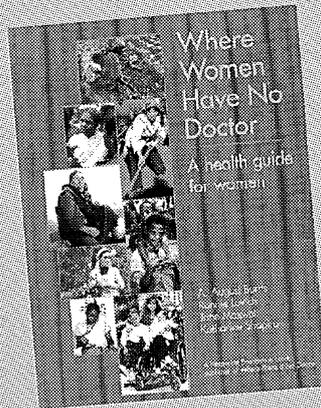
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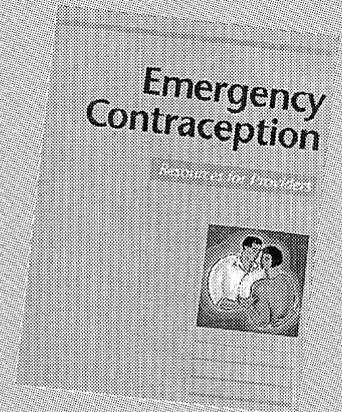
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An emergency contraceptive resource kit, which includes the American College of Obstetricians and Gynecologists publication *Practice Patterns on Emergency Contraception*, patient brochures and a manual for providers, is available from the Program for Appropriate Technology in Health (PATH). The kit was produced with support from the Kaiser Family Foundation. The manual for providers contains background



information, prescribing information, and patient education and consent materials. A kit may be obtained for U.S. \$10 by contacting the National Association of Nurse Practitioners in Reproductive Health (NANPRH — EC Kit), 503 Capitol Court NE, Suite 300, Washington, DC 20002 USA. Telephone: (202) 543-9693. Fax: (202) 543-9858.