Network

FAMILY HEALTH INTERNATIONAL, VOL. 13 NO. 1, AUGUST 1992

"THE FORGOTTEN 50 PERCENT"

TEENAGERS IN MEXICO

FINDING A "MALE PILL"

Men and Family Planning

News Briefs

GRIM AIDS OUTLOOK: 110 MILLION INFECTED BY 2000

The number of HIV infections by the year 2000 may be far higher than previously estimated, according to a research group's figures that place the worldwide epidemic at between 38 million and 110 million adults by that year.

Based on analysis performed in collaboration with 40 scientists, the U.S.-based Global AIDS Policy Coalition also concluded the following:

• AIDS is exploding in Southeast Asia, and by 2000 Asia will overtake Africa with the largest proportion of HIV-infected people worldwide. Asia will account for 42 percent and sub-Saharan Africa for 31 percent of HIV infections.

• AIDS is having a growing impact on women, who now account for 40 percent of HIV infections worldwide, up from 25 percent in 1990.

The coalition's predictions are far grimmer than previous estimates by the World Health Organization (WHO). In 1988, a group of WHO experts estimated up to 20 million adult infections by 2000. WHO revised its estimate this year to about 30 million adult infections by 2000.

The WHO "is underestimating both the scope of the problem and what will be needed in order to deal with the problem," says Dr. Jonathan Mann, who directed the coalition's work. International efforts to halt the spread of the disease have stalled and world leaders need to develop a new strategy to cope with the epidemic, he says.

The coalition's findings will be published this year in a book, *AIDS in the World 1992*, by Dr. Mann, Dr. Daniel Tarantola and Thomas W. Netter.

PLASTIC CONDOM STUDIES BEGIN AT FHI

The National Institutes of Health (U.S.) has awarded FHI $1.3 million to conduct clinical trials and other studies to evaluate FHI's plastic condom prototype.

By using a soft, thin plastic material instead of latex, FHI hopes to develop a new type of condom that is at least as strong as latex and less likely to fail, yet is more comfortable than latex. The four-year effort began in June.

The studies will include clinical trials involving volunteer couples to examine such issues as safety, how effective the plastic condom is in preventing pregnancy, and its acceptability to users.

Unlike latex, a natural material that loses strength with time, the plastic condom could be stored much longer without any decline in strength. It could also be used with any kind of lubricant, while latex should only be used with water-based or silicone lubricants.

Protective sheaths made of animal intestines or linen date to the 16th century while latex condoms were developed in the mid-19th century. Due mainly to the AIDS epidemic, interest in condom quality and effectiveness has increased in recent years. In 1990, approximately six billion latex condoms were used worldwide.

NEW INJECTABLE CONTRACEPTIVE

Cyclofem, a new monthly injectable contraceptive, is expected to become available in several countries during the coming year.

Local production and marketing of this reversible contraceptive should be under way in Indonesia, Mexico, and Thailand by early 1993, according to the Program for Appropriate Technology (PATH), making them the first countries to allow general use of the contraceptive. The product may also be approved for use in Chile, Jamaica and Tunisia by next year.

Injectable contraceptives protect against pregnancy by inhibiting ovulation and causing changes in the endometrium and cervical mucus. Like the current array of monthly injectable contraceptives in use, Cyclofem contains a combination of estrogen and progestin.

Compared with currently available two- or three-monthly progestin-only injectables, Cyclofem produces fewer side effects and allows women who discontinue use to return to fertility faster.

Cyclofem is the first monthly injectable to have completed extensive multi-centered clinical trials worldwide. More than two decades of study has been funded by the WHO. The 30-day injectable contraceptives currently in use around the world are largely untested, despite a long history of widespread use throughout Latin America and China.

In addition to a reduced incidence of bleeding irregularities, studies suggested nausea and headaches were less common among users of Cyclofem than for women using the two- and three-monthly progestin injectables.

PANEL RECOMMENDS DEPO-PROVERA IN U.S.

An advisory panel to the U.S. Food and Drug Administration (FDA) has unanimously recommended approval of Depo-Provera, an injectable contraceptive, for use in the United States.

Final action by the FDA is not expected for months. The FDA's Fertility and Maternal Health Drugs Advisory Committee made its June recommendation following a day of testimony from critics, supporters and experts.

This long-acting contraceptive, which provides three months of protection per injection, is already used widely around the world. Depo-Provera is approved for use as a contraceptive in 90 other countries and is approved in the United States for treatment of uterine and kidney cancers.

In 1978 and 1984, the FDA rejected previous advisory committees' endorsements of the drug for contraceptive use, citing insufficient information on such long-term effects as the risks for breast and cervical cancers. In recent years, studies have failed to show a clear link with the cancers.

At the panel's hearing, however, speakers for several women's advocacy groups questioned the studies and opposed approval of Depo-Provera. They expressed fears that women would face a somewhat greater risk of getting breast cancer. Several medical experts testified that there is no significant risk.

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IN THIS ISSUE

NEWS BRIEFS 2
- AIDS OUTLOOK
- PLASTIC CONDOM GRANT
- NEW MONTHLY INJECTABLE
- DEPO-PROVERA RECOMMENDED FOR U.S.

GETTING MORE MEN INVOLVED 4
FAMILY PLANNING METHODS FOR MEN 7
PILOT PROGRAMS INCREASE MEN'S INVOLVEMENT 8
USE OF MALE METHODS VARIES BY REGION 10
COMMUNICATION KEY FOR FAMILY PLANNING 13
MEXICAN AGENCIES REACH TEENAGERS 14
TARGETING MEN IN ZAMBIA 16
MEN'S ROLE VITAL IN BANGLADESH 18
LOOKING FOR A "MALE PILL" 20
TWO RESEARCH APPROACHES 23
AIDS PUTS CONDOMS IN SPOTLIGHT 24
MAKING VASECTOMY ATTRACTIVE 28

RESOURCES 31
NEW PUBLICATIONS 32

With this issue, the appearance of *Network* changes in an effort to serve our readers better. The cover, headlines and the way we use photographs will be obvious changes for most readers. Less apparent revisions include a new family of typefaces.

Getting More Men Involved

Men, "the forgotten 50 percent of family planning," are ready to take part if only asked.

Despite increased research and activities focusing on male involvement in family planning, experts say that much more could be done, particularly among providers. "We're still at the rhetoric level," says Dr. Cynthia Green, who has reviewed male involvement in family planning for the World Health Organization/Global Programme on AIDS. "Male programs have not received the attention they deserve."

Dr. Malcolm Potts, president emeritus of FHI, has campaigned for decades to expand the accessibility of contraceptive options. "If people really make vasectomy or the condom available to men, then the men come along and use them," he says. "The key bottleneck is on the side of the providers — not the men."

Jeffrey Spieler, a senior biomedical research advisor for the U.S. Agency for International Development (A.I.D.), adds, "We're trying to focus more on male involvement, but it's frequently more lip service than actual work. We need to turn the language into action." A combination of factors are contributing to this, he says. "We know how to provide family planning services to women better than to men, and there's been limited funding for male-only programs."

In recent years, organizations and experts working in the population field have recognized the need to involve men, "the forgotten 50 percent of family planning," as Dr. Potts puts it. What has resulted from this effort? Are men becoming more involved in family planning?

Answers to these questions require a review of two related themes: the use of so-called "male" methods and the role of men as decision makers in family planning, regardless of contraceptive method used. There are currently four methods requiring male involvement or participation, as summarized on page 7: condoms, vasectomy, withdrawal and periodic abstinence (rhythm).

Reviewing men's role as decision makers covers a broader scope, from research on changing attitudes to service delivery and educational strategies designed to reach men. Three important types of male involvement programs are personal contact through community outreach, information campaigns and services targeted to men.

"My gut feeling is that men are getting more involved," says Dr. Pramilla Senanayake, assistant secretary-general of the International Planned Parenthood Federation (IPPF). "But it's going to be a long process. We need many more programs on motivating and counseling men. No man would want to go to a maternal-child clinic. But men are concerned about looking after themselves, using the condom for AIDS prevention. And we're making progress at the workplace. I think the message is getting to them."

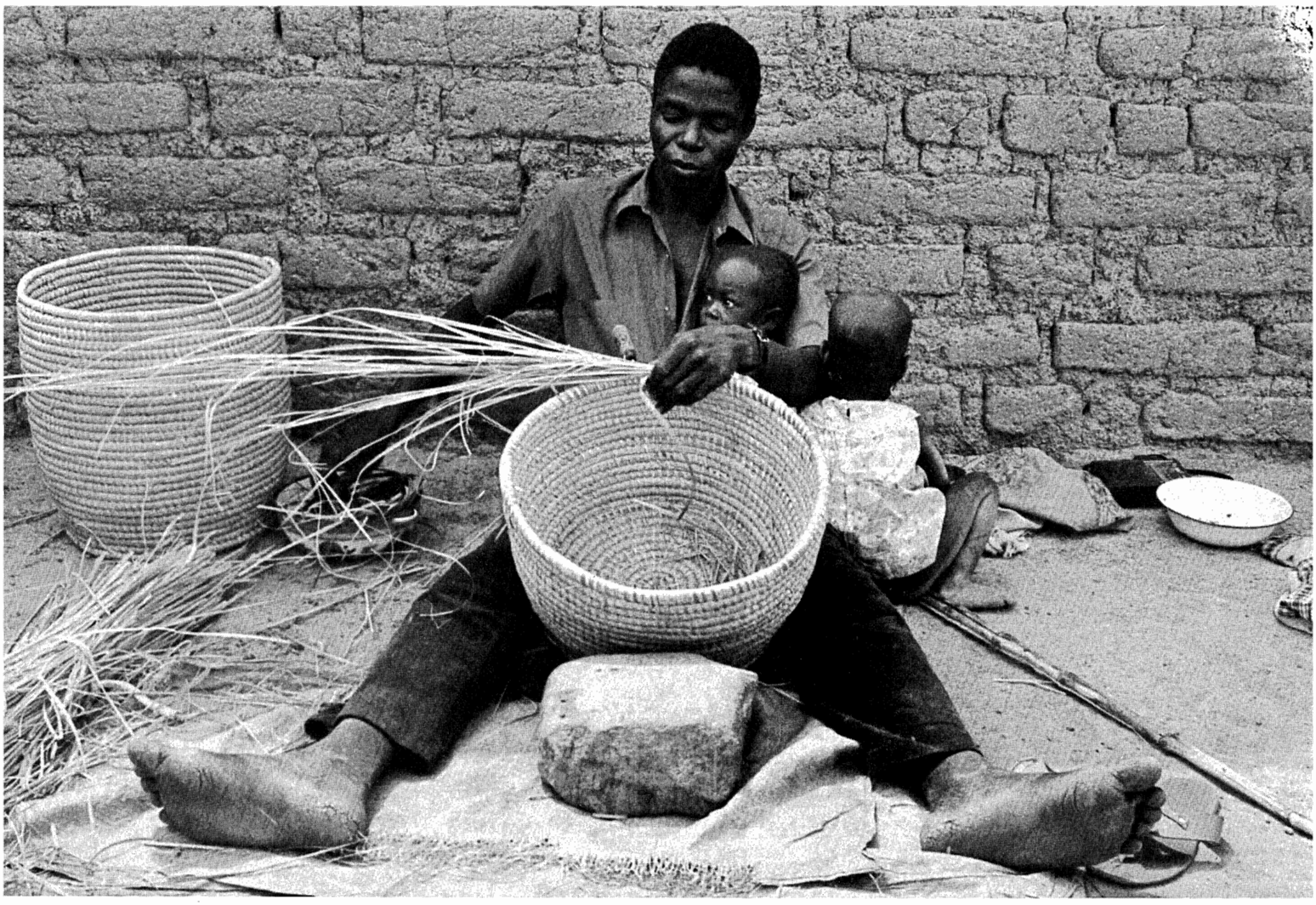
New attention on men

"Men have always been involved," says Dr. Potts. "They were the key element in the demographic transitions in many developed countries to smaller families, using condoms and coitus interruptus prior to the widespread use of the pill in the 1960s."

In the last generation, however, a female orientation has been at the forefront of family planning. The introduction of "modern" female methods — the pill, IUDs, injectables, and recently Norplant, among others — coincided with the establishment and growth of family planning programs in developing countries.

"The reasons for this female orientation in programs are clear enough: the very real threat excessive childbearing poses to women's health, the strong link between family planning and women's emancipation, and the political and practical decision in many developing countries to deliver family planning services through maternal/child health care networks," explains an IPPF report. While justifiable, this emphasis "has resulted in men being effectively excluded from many programs, either deliberately or through default," the report concludes.[1]

Three factors in the 1980s triggered more focus on the male role in the population equation. The coming of AIDS and its rapid spread through heterosexual contact has caused new attention and resources to be devoted to the condom and to understanding sexual health. Many organizations,



BERYL GOLDBERG

A FATHER IN BURKINA FASO CARES FOR TWO CHILDREN WHILE WEAVING BASKETS.

including FHI, have launched numerous research and intervention projects focusing on condom use and altering sexual behaviors.[2]

Second, the rights of women in developing countries has received substantial new attention, at least among policymakers and in urban areas. Two specific campaigns by the United Nations were "The International Decade for Women," capped in 1985 by a conference in Nairobi, Kenya, and a "Safe Motherhood" campaign, designed to educate people about maternal mortality and morbidity.

"Empowerment for women means that they can discuss contraceptive methods with their spouses more than used to be the case," says Dr. Senanayake. "Millions of women are dying in childbirth. Men are realizing that they can do something about preventing these deaths."

Third, while less obvious than the other two factors, the expansion of a new no-scalpel method of vasectomy from China to countries throughout the world has triggered new interest in male sterilization among advocates, providers and users. "The only male method that will have a significant demographic impact in my lifetime is vasectomy or some form of vas occlusion (blocking the tube transporting sperm)," says Spieler of A.I.D.

MEN AND DECISION MAKING

In 1983, in one of the first global consultations on this subject, the IPPF described male programs as activities focusing on men as a separate group, designed to increase "the acceptability and prevalence of family planning practice of either sex." Such projects could be aimed at the male partner himself or at influential male leaders in religious, medical, political, community and workplace settings.[3]

Such projects, historically, have assumed that men were generally the obstacle in family planning programs in developing countries, with some justification. "In most societies, men play a dominant role in decision making regarding fertility and family planning. Numerous studies have found that a woman's partner influences not only whether she will use family planning but also how well she will use her chosen method," explains Dr. Green in her analysis for WHO.[4]

Surveys indicate that at least one-third of men believe that family planning should be a joint decision.[5] The other two-thirds think the male should make the decision. In addition, recent reports have found that while male attitudes are more positive than originally thought, significant obstacles also exist.

"Men are deeply troubled about household finances and the health of their families," write Therese McGinn, formerly of Columbia University, and Azara Bamba, formerly of the Burkina Faso Ministry of Health and Social Affairs. "Men are open to learning about and using modern contraceptives. But men do have concerns about family planning. They fear losing their children to the all-too-familiar ravages of disease. They fear the new drugs and devices that are reputed to harm their users. They fear, probably correctly, that it will change the balance of social control between men and women."[6]

Researchers have also found that attitudes are easier to change than are behaviors, and that there is a need for getting specific information and services to men. "There is a tremendous gap between positive attitudes and actual practice," report researchers from the Program for Appropriate Technology in Health, in a review of work on men and family planning in

Africa.[7] "The challenge of the '90s for family planning supporters is filling this gap."

In November 1991, representatives from eight African family planning associations and others met in The Gambia to review the efforts being made to reach men. Many of the programs had developed information campaigns to increase male awareness. "One of the crucial questions now facing these programs is how to move beyond increasing knowledge to changing attitudes and practice," the workshop report explains.[8]

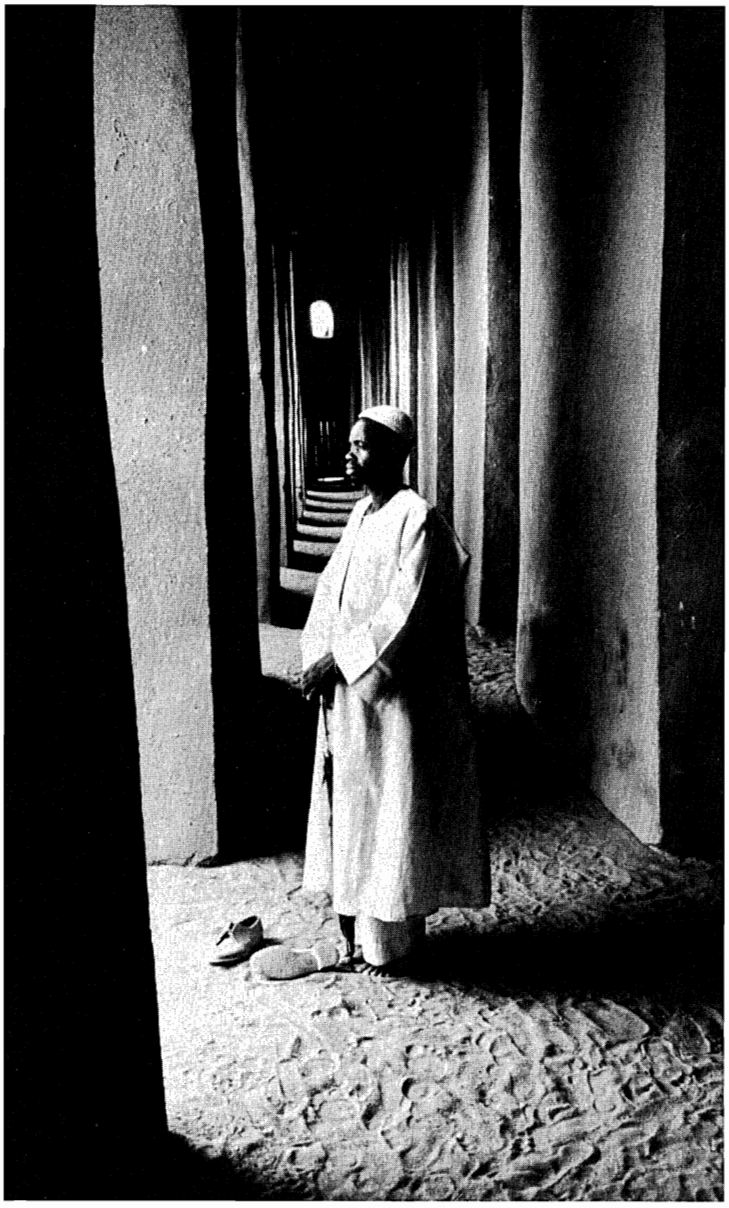
The report summarizes efforts being made to reach men through employment-based programs, youth programs, peer counseling, social marketing efforts and AIDS prevention programs. It also emphasizes the importance of services encouraging joint decision making by couples. The report concludes that the most effective and sustainable programs will be those clinics and community-based services that are acceptable and appropriate to both women and men, rather than those separating service delivery systems according to gender.

Experts have not reached consensus on how to provide the services men need, but realities of limited resources suggest that separate services for men and women will be difficult. "I don't know if there's enough money to have clinics for maternal and child health, for family planning that caters to women and for family planning that caters to men," says Spieler of A.I.D.

Regardless of exactly how new services get men more involved in the family planning equation, experts agree that there is great potential. "There is tremendous interest out there," says Dr. Green. "It has not been capitalized on. When the services are offered in a sympathetic and high-quality way, men will use them."

In most developing countries, family planning is still a relatively new concept, less than a generation old. "We started family planning with women," says Dr. Roberto Rivera, FHI corporate director for international medical affairs and a native of Mexico. "That took time. Now it has gotten to a stage where it is accepted by the family, which has opened the door to men. Mexico is a good example. People now accept the freedom of choice more, with effective methods for women available. Now we can afford politically and socially to concentrate also on the role of men."

— *William R. Finger*



UN/JOHN ISAAC

MAN ENTERING A MOSQUE IN MALI.

FOOTNOTES

1. *Male Involvement in Family Planning: Report of an IPPF Staff Consultation.* London: International Planned Parenthood Federation; February 1984: 1.

2. General resources include Strategies for Behavior Change: Slowing the Spread of AIDS. *Network*. 1991; 12(1); *HIV Infection and AIDS: A Report to Congress on the USAID Program for Prevention and Control*. U.S. Agency for International Development; 1991; and publications of the Global Programme on AIDS/World Health Organization.

3. P Meredith. *Male Involvement in Planned Parenthood: Global Review of Strategies for Programme Development*. London: International Planned Parenthood Federation; 1990: 5.

4. CP Green. *Male Involvement Programs in Family Planning: Lessons Learned and Implications for AIDS Prevention* (draft). Global Programme on AIDS/WHO; March 1990: 2.

5. Green, pages 3-4.

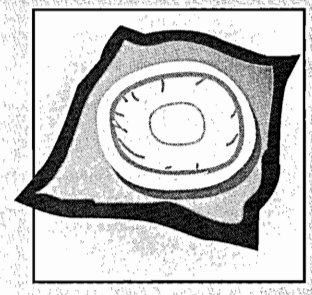
6. T McGinn, A Bamba, M Balma. Male Knowledge, Use and Attitudes Regarding Family Planning in Burkina Faso. *International Family Planning Perspectives*. 1989; 15(3): 87.

7. S Haile, P Bartlett. Family Planning in Africa: Are Men Really an Obstacle? Paper presented at the Conference of the American Public Health Association, 1991, p. 12. Available through Program for Appropriate Technology in Health.

8. *Male Participation in Family Planning, Workshop Report, The Gambia, November 25-28; 1991.* London: International Planned Parenthood Federation. Quotes from pages 1 and 14.

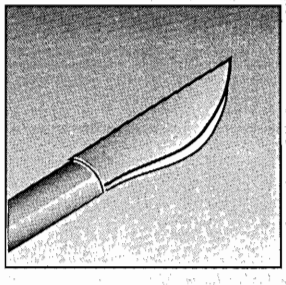
Family Planning Methods for Men

Condoms



Condoms were used in 1990 by about 45 million couples worldwide, with the greatest percentage of users in Japan, Hong Kong and Taiwan. In developing countries, about 4 percent of married couples, or about 24 million people, use condoms for family planning. Several Latin American countries report more than 10 percent of married couples using condoms, with the lowest rates in sub-Saharan Africa (less than 1 percent). Condoms are safe, simple to use, effective when used correctly at every coitus, do not require medical supervision, can be obtained cheaply in most countries and help prevent transmission of the AIDS-causing virus, HIV. On the other hand, condoms may affect sensitivity during intercourse, interfere with foreplay, require negotiation and have a connotation of disease prevention. Failure is usually caused by improper and inconsistent use, and condoms weaken and can break if stored improperly or used with oil-based lubricants.

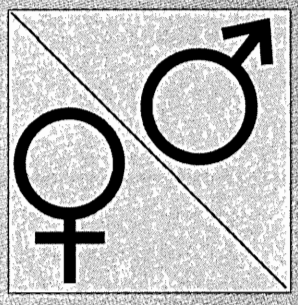
Vasectomy *(male sterilization)*



A minor surgical procedure that takes about 15 minutes to perform, vasectomy is 99 percent effective against pregnancy and is one of the safest contraceptive methods. Most men experience only minor bruises or pain immediately after surgery. Serious complications are rare. As of 1991, about 42 million men with wives of reproductive age had had a vasectomy. A newer procedure developed in China, called the "no-scalpel" vasectomy, uses a tiny puncture instead of a scalpel cut to gain access to two tubes in the scrotum that transport sperm. This new procedure is quicker, has fewer complications and evokes less fear since a scalpel is not used. The tubes, called *vasa deferentia*, are blocked under either method, typically by tying, cutting or cauterizing. Vasectomy should be considered a permanent form of contraception. Although some men have had fertility restored using expensive microsurgery, the reversal operation is not readily available in most countries and does not always work.

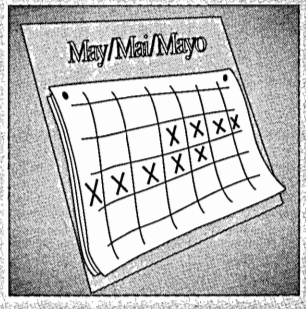
Withdrawal

(coitus interruptus)



The oldest method of contraception known, it was widely used in Europe for centuries. As of 1986, some 35 million couples worldwide used withdrawal. Of these, 13 million were in developing countries, with the highest rates in Latin America, where about 6 percent of married couples in several countries used this method. For this method to be effective, the man must withdraw his penis from the woman's vagina before ejaculation, which must occur completely away from her vagina and external genitals. Even though experts report typical failure rates of about 18 percent, it is free, safe, and requires no supplies or medical supervision.

Periodic abstinence *(rhythm)*



The oldest and most frequently practiced form of periodic abstinence is the calendar method, avoiding intercourse during the middle of the menstrual cycle. Since the 1950s, three additional methods have been developed: temperature, cervical mucus and sympto-thermal, where both cervical mucus and temperature are observed together. A woman's basal body temperature, the lowest temperature upon waking, varies with ovulation, as does the thickness of a woman's cervical mucus, thus providing clues to the fertile period. As of 1986, an estimated 31 million married couples of reproductive age used periodic abstinence, almost half of these in developing countries. The highest use rates are in Latin America. Effective use of this method requires that a couple know the correct time of the woman's fertile period and avoid intercourse during that period. This method has high rates of unplanned pregnancies, about 20 percent, with the calendar method the least reliable. Some experts refer to periodic abstinence as "fertility awareness" or natural family planning.

Primary Sources: RA Hatcher, F Stewart, J Trussell, et al. *Contraceptive Technology, 1990-1992.* New York: Irvington Publishers, Inc.; 1990; Men — New Focus for Family Planning Programs. *Population Reports.* 1986; Series J (33); Vasectomy: New Opportunities. *Population Reports.* 1992; Series D (5); Association for Voluntary Surgical Contraception; Levels and Trends of Contraceptive Use as Assessed in 1988. *Population Studies.* United Nations; 1989: No. 110.

Pilot Programs Increase Men's Involvement

Projects in three world regions show that concerted efforts can reach men with family planning information.

Increasing men's involvement in family planning requires creative initiatives that incorporate the unique circumstances of an individual community and culture. Successful pilot projects in Pakistan, Zimbabwe and Colombia have shown that much can be accomplished if the proposition from the United Nations Population Fund is taken seriously: "lack of useful information and services, rather than lack of interest, has kept men from taking a more active role in family planning."[1] These three projects have also shown that much remains to be done.

MEN IN DHAKA AWAIT FAMILY PLANNING COUNSELING AT A CLINIC.

BERYL GOLDBERG

In the Pakistani city of Mardan, in a remote mountain area near the famous Khyber Pass to Afghanistan, a local group called the Urban Community Development Council (UCDC) has spearheaded a project of community education to involve men in family planning. The project advisors include the top government official in the region, as well as religious leaders in this Sunni Muslim area.

Mardan, a city of 200,000, is composed largely of Pathans, a large ethnic group known for warfare, poetry and a rigidly enforced honor code. Purdah, the conservative Muslim tradition of secluding and veiling women, is strictly observed. A 20-year-old community development organization, UCDC has an all-male membership of 200 representing all segments of Mardan.

Since 1988, some 60 community educator teams with five members each have visited families throughout the city. Initially, these teams were all male. Then one of the teams reported to the managing committee that some of the men contacted wanted a woman to explain family planning methods to their wives. Finding enough women free to move about as team members was difficult in this conservative environment, but women were eventually added to about 40 of the teams.

"We have challenged assumptions regarding religious and social conservatism and the role of men in promoting family health through family planning," says Imtiaz Kamal, a Pakistani nurse and the Pakistani representative for Pathfinder International. The results have been dramatic. In four years, the contraceptive prevalence rate among married couples increased from 9 percent to 21 percent.

"The contraceptive trends during the project have been from very temporary methods to longer lasting methods — more IUDs, sterilization and injectables," says Kamal of Pathfinder, which has provided technical assistance to UCDC using funds from the U.S. Agency for International Development (A.I.D.). "We have had a few vasectomies, which is a big breakthrough."

Other community groups contribute an esti-

mated US $541 per month to the project for staff salaries, clinic utilities and medical supplies. "The ability of UCDC to involve these other groups has been very influential in the project's success," adds Kamal.

A similar project has been attempted in Karachi, Pakistan's capital, without such success. "The large city mentality is different," says Kamal. "The support of many groups is missing. It is a 'what's in it for me?' attitude. People don't know their neighbors and don't have the same kind of affiliations."

The same year UCDC began its local community education and service delivery campaign in Pakistan, a continent away the Zimbabwe National Family Planning Council (ZNFPC) launched an ambitious nationwide male motivation project. In 1988, 43 percent of Zimbabwean couples of reproductive age used some contraceptive method. Even so, surveys showed that nearly half of married women believed that men alone should be responsible for family planning decisions.

The ZNFPC developed a national education project addressed exclusively to men, the first such effort in sub-Saharan Africa. The project was designed to increase knowledge of family planning, to promote more favorable attitudes among men, to increase modern family planning methods and to promote joint decision making. In 1988 and 1989, the project heavily promoted such messages through a popular radio serial drama, motivational talks and family planning leaflets. The Johns Hopkins University Population Communication Services program provided technical assistance to the effort, with funds from A.I.D.

An extensive evaluation of the campaign found that the radio drama was by far the most effective, reaching about two of every five men surveyed, covering both urban and rural areas. The talks and leaflets reached 11 percent and 5 percent of men, respectively. From 1988 to 1989, the portion of men reporting that family planning is a joint decision increased from 25 percent to 35 percent.

The information generated by the project pointed the Zimbabwe family planning leaders in two important directions. Initial acceptance of family planning in sub-Saharan countries has often been linked with the idea of spacing children by using temporary methods such as oral contraceptives. "If limiting rather than spacing births is to become a reality, the ZNFPC must promote more permanent family planning methods," the project report concluded.

Regarding condom use, the survey data indicated that messages to different populations are needed. "The ZNFPC should consider developing separate campaigns for single and married men to reflect their different interests in family planning."[2]

Across the Atlantic Ocean in South America, a different service delivery strategy — creating male clinics — has also challenged traditional thinking about men. In 1985, PROFAMILIA in Colombia, one of the largest and most established family planning organizations in the world, opened its first clinic for men in Bogota, the capital. PROFAMILIA followed the lead of Pro-Pater, a private family planning organization in Brazil, which had started a similar clinic in São Paulo.

The Bogota clinic has a separate entrance and waiting room for men but is connected to the female clinic as a cost efficiency measure. "Men have to get a clear impression that they get a different kind of attention," says Dr. Miguel Trias, executive director of PROFAMILIA.

PROFAMILIA currently operates 50 clinics nationwide, eight of them for men. The male clinics have developed from the Bogota model, which is on a major boulevard with a large sign reading "Clinica para el Hombre" (Clinic for Men). Initially, the clinic used only male interviewers but now uses both male and female nurses, while being careful to help men feel at ease through the clinic structure and to ensure them that their privacy is being respected.

In addition to performing vasectomies and distributing condoms, the clinic provides other services that produce surplus income for the clinic, including laboratory services, urology, diagnosis and treatment of sexually transmitted diseases and counseling on sexuality. By offering these services, the Bogota clinic and one other male clinic are totally self-sustaining, says Dr. Trias.

"The male clinics discovered that by diversifying their activities, you could charge for some services and earn enough to put that into family planning, a money-losing activity," says Dr. Trias. "The male clinics were the first to diversify. They showed us the way for our overall program. Having self-sustaining clinics is not easy to accomplish in nongovernmental family planning clinics."

The New York-based Population Council found the PROFAMILIA male program highly successful due to its "careful determination of what is important to clients — a very attractive facility, individualized care, a wide range of services, low-cost vasectomy and Saturday hours."[3]

The projects in Pakistan, Zimbabwe and Colombia challenged conventional assumptions while also tapping the existing resources and ingenuity in their own areas. Rural men in Zimbabwe have radios, so the serial drama reached them and influenced their thinking. The UCDC has legitimacy in an isolated mountain city in Pakistan, providing a means of getting men involved. Colombian men wanted help with urological problems and were willing to discuss vasectomies in a safe setting where their pressing needs were met with sensitivity.

PATHFINDER INTERNATIONAL

A BOOTH AT A MALE INVOLVEMENT FAIR ENCOURAGES PAKISTANI MEN TO LEARN ABOUT FAMILY PLANNING.

Yet many challenges lie ahead. The Pakistan program relies heavily on outside funding, which is often precarious. The Zimbabwe Family Planning Council faces a major educational challenge regarding condom use among unmarried men and vasectomy. In Colombia, the number of men getting vasectomies is increasing, but in 1991, only 5,000 men were sterilized compared to 70,000 women, says Dr. Trias.

"We still have a long way to go to make family planning less biased towards women," Dr. Trias says. "It will never be equal, but maybe we can someday get the ratio of sterilization down to about three or four females for each male."

— *William R. Finger*

FOOTNOTES

1. N Sadik. *The State of World Population 1991*. New York: United Nations Population Fund (UNFPA): 23.

2. I Kuseka, T Silberman. *Male Motivation Impact Evaluation Survey*. Zimbabwe National Family Planning Council Evaluation and Research Unit; June 1990: 8.

3. D Rogow. Man/Hombre/Homme: Meeting Male Reproductive Health Care Needs in Latin America. Special issue of *Quality/Calidad/Qualité*. The Population Council; 1990: 17.

Use of Male Methods Varies by Region

More couples are using methods requiring men's participation, yet the percentage of couples using these methods has declined in some areas and increased in others.

In the 1980s, an important change in contraceptive use occurred. The percent of couples using methods involving men appears to have *declined* in much of Latin America, but *increased* in Asia, Africa and the Near East. These trends emerged from an analysis of nationwide survey data collected in 18 developing countries at the beginning and at the end of the 1980s, through World Fertility Surveys, Contraceptive Prevalence Surveys and Demographic and Health Surveys.[1]

The data on methods used, together with attitudinal information, suggest that men are not as involved in family planning as they might be. Government and non-governmental family planning programs will need to increase outreach efforts to men, by encouraging men to support the use of family planning by their partners and by improving information about, and availability of, methods involving direct male involvement.

MORE COUPLES ARE USING MALE METHODS IN ASIA, AFRICA AND THE NEAR EAST.

B. GENIER / WHO

Contraceptive methods can be characterized by whether they are typically initiated and used by the male or the female partner. The four methods of contraception that require the participation or cooperation of men are male sterilization (vasectomy), condoms, withdrawal, and periodic abstinence (rhythm), described on page 7. These are referred to hereafter as male methods. Periodic abstinence, considered by some experts as a couple or female method, is included here as a "male method" because men must cooperate for it to be used as a contraceptive method.

In virtually all countries, the use of male methods has increased in absolute terms due to increases in population and overall contraceptive use. However, the percentage of couples using male methods has increased in some countries and declined in others, while the percentage of couples using female methods has generally increased throughout the world.

It is important to note the distinction between the percentage of use of male methods among all married couples (which includes many couples who do not use any form of contraception) and the percentage of use of male methods only among the contraceptive users. For example, Figure 1 shows that about 25 of every 100 married couples in Sri Lanka use male methods. If one were to consider the smaller group of only the married couples who use some form of contraception, the percentage who depend upon male methods would be higher. It happens to be 41 percent in Sri Lanka (not shown in Figure 1).

The surveys cited here asked women what method of contraception they were currently using. Some of the surveys questioned all women of reproductive age (15 to 49), while others gathered data from women of reproductive age who were either married or in union, referred to below as wives. All surveys reported data on contraceptive use for wives. These are the data presented in this article.

These data have several limitations. Most surveys questioned only women, who tend to report lower use of male methods than do men.[2] A review of the few surveys that also interviewed husbands found this reporting difference to be true (see page 13). Second, data from two different surveys for the same country are not always completely comparable. Finally, data for two points in time are not available for such large countries as India, Brazil and Nigeria. Even so, the trends described below do offer some basis on which policymakers and program planners can base future decisions regarding service delivery of contraceptives.

Figure 1 ranks 28 countries according to the

percentage of male methods being used, as reported in the latest available surveys.[3] Six Latin American countries rank among the top seven, led by Peru, where more than one of five couples used a male method. Topping the list was Sri Lanka in Asia, where 25 percent of couples used a male method.

Figure 1 shows that married couples in Latin American countries tend to use male methods more than do couples in other parts of the world. Even so, the percent of couples using male methods is declining in many parts of Latin America, as shown in Figure 2.

Figure 2 gives trend data on use of male methods for the 18 countries having two surveys. For each of the countries, the use of the four male methods was totaled and reported for two points in time, for 1976 to 1980 and 1987 to 1991. The years of comparison vary, depending upon the year of the surveys in each country.

In four Latin American countries, the percentage of users reporting male methods declined during the decade; in Mexico and Peru, the percentage increased. In 10 of the other 12 countries, the portion of total male methods increased. In Indonesia it remained the same, and in Thailand it decreased.

The method most responsible for the shifts in trends was rhythm. In 10 of 12 countries outside of Latin America, the percentage of couples using rhythm increased during the decade; the percentage in Egypt remained essentially the same while in Thailand it declined. In four of the six Latin American countries, the percent using rhythm declined, while in Mexico and Peru it increased.

By the end of the decade, in 13 of the 18 countries, rhythm accounted for the highest percentage of users among the male methods. Condom use led in Trinidad and Tobago, Egypt, and Pakistan. Vasectomy led only in Thailand; withdrawal and rhythm tied for first in the Dominican Republic.

Use of condoms remained low in most countries and did not increase substantially during the decade. Among the 18 countries analyzed, only Pakistan and Bangladesh had a rise of more than 1 percent in couples using condoms during the 1980s. Both countries had active condom social marketing projects during this period. It is important to note that most of the recent surveys were conducted in the late 1980s, prior to major national efforts to promote condoms for AIDS prevention.

Male sterilization was reported in the Asian countries, and growing numbers used this method in Latin America. In the African countries and in Pakistan and Peru, no use of vasectomy was reported even at the end of the decade. Bangladesh, Sri Lanka and Thailand were the only countries where more than 1 percent of wives reported use of vasectomy, with all three countries showing substantial increases during the decade.

Among Latin American countries, the percent of couples using condoms fell sharply in the Trinidad and Tobago survey, from 18 percent to 12 percent, with smaller declines in Colombia, Dominican Republic, Ecuador and Peru. In Mexico, condom use almost doubled, from 1.1 percent to 1.9 percent. The percent of rhythm users declined slightly in the Latin American countries except for Mexico and Peru, where it increased. The trends varied for withdrawal and vasectomy.

In Asia, increases in percent using male methods were notable in Sri Lanka, from 12.5 percent to 25 percent. Rhythm jumped from 8 percent to 15 percent there, with vasectomy increasing dramatically, from less than 1 percent to 5 percent. Bangladesh had increases in all four male methods, with condoms more than doubling from less than 1 percent to 2 percent. Pakistan had the largest overall jump, from 1 percent to 5 percent, with condom use nearly tripling. In Thailand, the only male method to show an increase in percent of users was vasectomy, which has been highly publicized there.

In sub-Saharan Africa, the increases of male methods were due primarily to rhythm. Rhythm use in Ghana jumped from 1 percent to 6 percent while in Kenya it increased from 1.5 percent to 7.5 percent and in Sudan went from 0.4 percent to 2 percent. In North Africa, the increases came from condom use in Egypt and withdrawal in Morocco. The trend in Tunisia is not clear because use of rhythm was not reported in the 1978 survey.

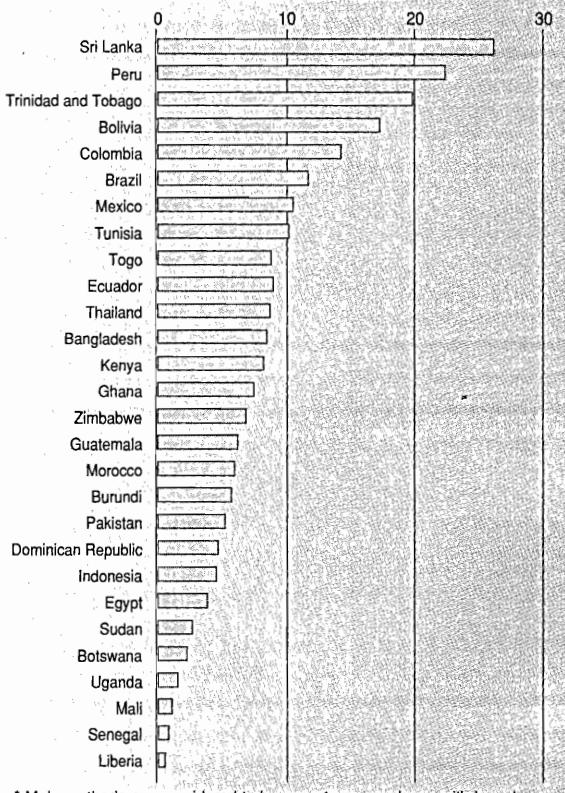
In countries with high and growing levels of overall contraceptive prevalence — counting oral contraceptives, the IUD and other modern female methods — male methods as a percentage of all methods tend to go down. This was true in five of the six Latin American countries (all but Mexico), as well as in Bangladesh, Indonesia and Thailand. All three of these Asian countries had sharp increases in overall contraceptive prevalence. In Sri Lanka, male methods as a percent of all methods remained about the same, since both overall prevalence and use of male methods increased sharply.

In sub-Saharan and North Africa, male methods as a percent of all methods increased in six of seven countries. Only in Senegal, where the overall contraceptive prevalence nearly tripled, did male methods decline as a portion of overall methods used.

These trend data are most useful when put in the broad context of male attitudes toward family planning, number of children desired, future intentions to use family plan-

FIGURE 1

PERCENT OF COUPLES OF REPRODUCTIVE AGE USING MALE METHODS*

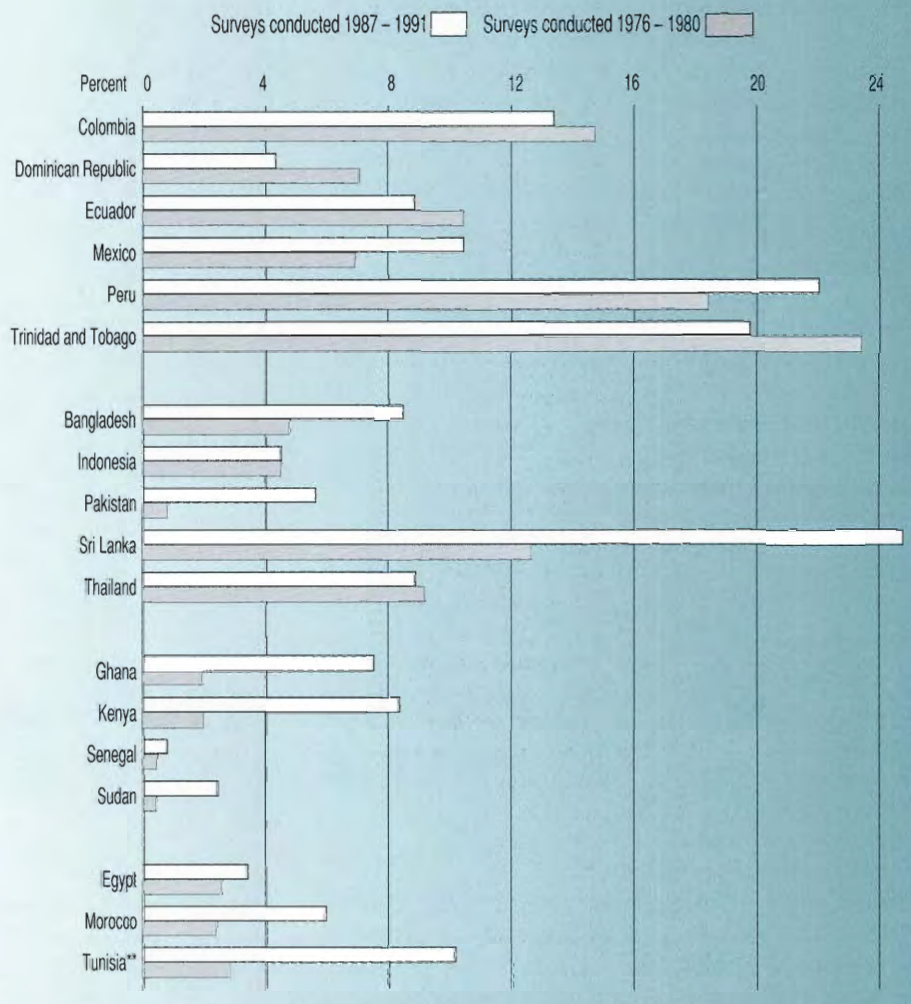


* Male methods are considered to be vasectomy, condoms, withdrawal and periodic abstinence. The percentages are reported by married women of reproductive age.

Sources: Demographic and Health Surveys, Contraceptive Prevalence Survey, 1986-91

FIGURE 2

TRENDS IN PERCENT OF MARRIED COUPLES OF REPRODUCTIVE AGE USING MALE METHODS*



* Male methods are considered to be condoms, vasectomy, withdrawal, and periodic abstinence. The percentages are reported by married women of reproductive age.

** The 1978 total for Tunisia does not include periodic abstinence because data were not collected on it.

Source: See Footnote 1

ning, and the choices of methods available and accessible. In the most recent nationwide surveys conducted by the international Demographic and Health Surveys (DHS) project, for example, wives generally thought their husbands approved of family planning. In 10 of 11 countries for which data are available, husbands' opposition accounted for less than 10 percent of the reasons given for non-use of family planning among the wives.[4]

Generally, fewer than one of every 10 wives reported in the recent DHS data that they plan to use a male method in the future. The results were similar in the four published surveys that also questioned husbands, although husbands did indicate more interest in male methods.

The trend data on methods used, together with the attitudinal information, suggest that men could be more involved in family planning. One way to address this lack of involvement, in the short run, is to encourage men to discuss family planning and desired family size with their wives, and to support the use of family planning by their wives. But in the long run, more attention needs to be given to providing male methods as well. This will allow men and women to have the widest range of options for involving men as well as women in family planning.

— Dr. Karen Hardee-Cleaveland

Dr. Hardee-Cleaveland, a social demographer, is senior research associate in FHI's Division of Program Evaluation.

FOOTNOTES

1. In these 18 countries, a World Fertility Survey (WFS) or Contraceptive Prevalence Survey (CPS) was conducted in the late 1970s and a Demographic and Health Survey (DHS) or CPS was undertaken in the late 1980s. The countries and surveys with dates and survey source are:

Africa:				
Ghana	WFS	1979-80	DHS	1988
Kenya	WFS	1977-78	DHS	1988
Senegal	WFS	1978	DHS	1986
Sudan	WFS	1977-78*	DHS	1989-90*
North Africa/Near East:				
Egypt	WFS	1980	DHS	1988
Morocco	WFS	1979-80	DHS	1987
Tunisia	WFS	1978	DHS	1988
Asia:				
Bangladesh	CPS	1979	CPS	1989
Indonesia	WFS	1976**	DHS	1987
Pakistan	WFS	1975	DHS	1990-91
Sri Lanka	WFS	1975	DHS	1987
Thailand	CPS	1978	DHS	1987
Latin America/Caribbean:				
Colombia	WFS	1976	DHS	1986
Dominican Republic	WFS	1975	DHS	1986
Ecuador	WFS	1979	DHS	1987
Mexico	CPS	1978	DHS	1987
Peru	WFS	1977-78	DHS	1986
Trinidad and Tobago	WFS	1977	DHS	1987

* Coverage for Northern Sudan only.
** Java and Bali only

2. G Ahmed, WP Schellstede, NE Williamson. Underreporting of Contraceptive Use in Bangladesh. *International Family Planning Perspectives*. 1987; 13(4): 136-40.

3. For 18 of the 28 countries shown in Figure 1, the source of the data is shown above in footnote 1, the two right-hand columns. The sources for the other ten countries are all DHS surveys with the dates of the survey fieldwork in parentheses: Bolivia (1989), Botswana (1988), Brazil (1986), Burundi (1987), Guatemala (1987), Liberia (1986), Mali (1987), Togo (1988), Uganda (1988-89) and Zimbabwe (1988-89).

4. The 11 DHS surveys with this data are: Botswana, Ghana, Kenya, Sudan, Zimbabwe, Egypt, Morocco, Bolivia, Trinidad and Tobago, Sri Lanka and Thailand. Only in Sri Lanka did the husband's opposition account for 10 percent or more of the reasons for non-use of family planning among wives.

Communication Key for Family Planning

Four reports published by Demographic and Health Surveys (DHS) include information from husbands of the wives interviewed in the main part of the survey. All are from Africa — Burundi (1987), Ghana (1988), Kenya (1988) and Mali (1987). These surveys of husbands indicate the importance of programs that work to improve communication between spouses about family planning.

In particular, they show a positive association between contraceptive prevalence and husband and wife communication about family planning. Husbands and wives were asked how often they discussed family planning in the past year. In Kenya, with a 27 percent contraceptive prevalence rate — the highest among the four countries — about two-thirds of the couples had discussed family planning during the past year. In Ghana, with a rate of 13 percent, and in Burundi, at 9 percent, about half of the couples had discussed family planning during the year. Mali had the lowest contraceptive prevalence rate of 5 percent and the least communication among the couples, with only one-fourth discussing family planning during the year.

The importance of communication also emerges in data on methods used. In all four surveys, the wives reported lower use of male methods than did their husbands. Estimates of use of female methods were more consistent between husbands and wives. Questions were not exactly the same in all four surveys, so summaries for each country vary slightly.

In Burundi, about two of five husbands said they used periodic abstinence, compared to about one of five wives. Husbands said 0.7 percent used condoms, with 0.3 percent of the wives giving that response. Husbands and wives agreed that there was no use of male sterilization. The use of vasectomy in Africa is considerably lower than for other regions of the world (see chart below).

Ghana showed a similar pattern. Husbands said 2.1 percent of couples used condoms, compared to 0.3 percent according to the wives. Husbands also indicated more widespread use of periodic abstinence than did the wives. In contrast, except for pill use, husbands and wives gave similar responses for use of female methods.

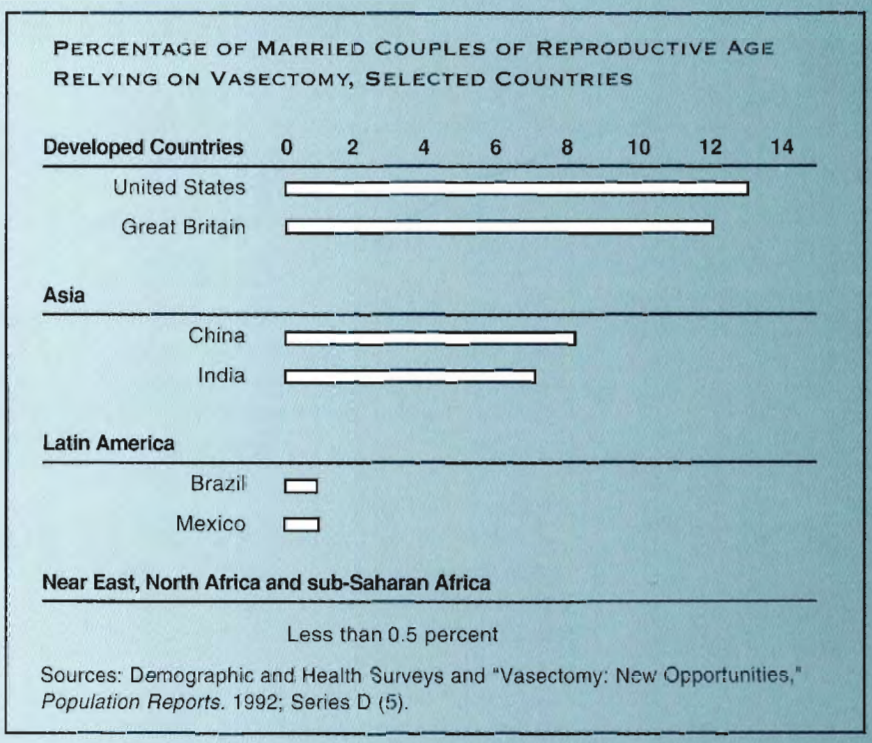
In Kenya, one of every two husbands said they were using family planning, compared to about one of every four wives. The largest discrepancy was in the data for use of periodic abstinence, where three times more husbands than wives said they were using this method — 26 percent compared to 8 percent.

Only in Mali, where total contraceptive use is only 5 percent, were responses from husbands and wives consistent. Even here, husbands gave higher rates of condom use (0.5 percent) than did wives (none).

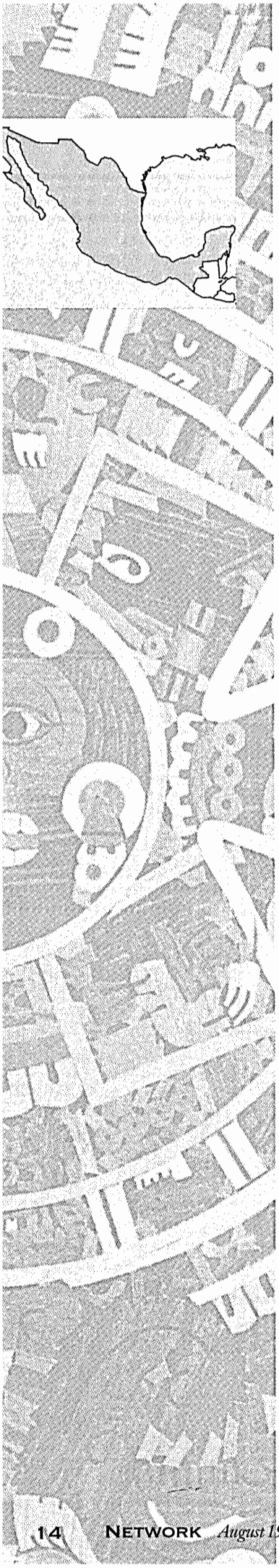
When it comes to choosing a method of family planning, women apparently think first of female methods. In general, women assume that their husbands will not be interested in using contraception themselves. Women may, however, underestimate their husbands' interest or participation in family planning. Or men could be overstating the use of male methods. These DHS husband surveys suggest that programs aimed at both men and women should encourage more and better communication between spouses about family planning.

More data related to communication on family planning will soon become available. Other DHS husband surveys in various stages of completion are from Pakistan, Cameroon, Tanzania and Egypt.

— Dr. Karen Hardee-Cleaveland



Sources: Demographic and Health Surveys and "Vasectomy: New Opportunities," *Population Reports*. 1992; Series D (5).



Mexican Agencies Reach Teenagers

MEXICO CITY, Mexico — Four years ago, officials from the Mexican Foundation for Family Planning (MEXFAM) spent a week in the Mexico City school where Javier Espinosa Garcia, then 15, was a student. Espinosa Garcia heard the MEXFAM representatives talk about the problems of population growth and sexually transmitted diseases, and he heard their appeal for the students to help spread these messages among their peers.

"I was the only one in the school to sign up," Espinosa Garcia, now 19, recalls during an interview in the national MEXFAM office in Mexico City, a vast metropolis of some 20 million people. He went through a month-long training course, part of MEXFAM's "Gente Joven" (Young People) project. Then, working as a volunteer for MEXFAM, he began talking to his friends about these issues.

"I provide information to young people who are about my age and to some adults," he says. "I answer their questions and help them with their doubts. And I distribute contraceptives — condoms and spermicides."

Over time, word of Espinosa Garcia's work spread. "Friends come to see me now," he says. "I do this in the school as much as outside." He talks to about 20 to 30 people a week, even when school is not in session. "More than anything else, people ask me about contraceptive methods."

Before he began his work with MEXFAM, a friend of his, then 18, did not know much about contraception. "He got his girlfriend pregnant, and they had to get married," says Espinosa Garcia. "If they had been informed, this would not have happened. Since I joined MEXFAM, the two of them have been getting contraceptives from me, so they still have only one child."

MEXFAM, the nationwide family planning organization in Mexico affiliated with the International Planned Parenthood Federation (IPPF), has sponsored the work of young men and women such as Espinosa Garcia in 19 cities throughout this country of 88 million. During the six years of its "Gente Joven" project, MEXFAM has spread its message through a series of films, materials and peer educators such as Espinosa Garcia. In the first four months of 1992, 27,000 young people throughout the country participated in the project.

Influencing the behavior of young men in this project is particularly challenging. A Latin image of machismo or manliness is pervasive, influencing how young men relate to women in many respects including sexuality. Traditionally, family planning programs have focused on women, and there have not been easily accessible opportunities for education about reproductive health among young men.

"It's very difficult to change the machismo here in terms of the responsibility of young men for pregnancy," says Gabriela Rodriguez, MEXFAM's director of research, education and training, which includes the "Gente Joven" project. "It is deeply ingrained in our culture. I don't think we are changing very significantly yet, but we are starting. While we can't ignore the older men, we can do much more with youngsters. They can change much more."

Nearly half of the teenagers in Mexico are engaged in sexual relations, reports Dr. Arturo Zarate Treviño, general director of family planning for the Ministry of Health. "But the protection they take is minimal," he says. What often results are quick marriages or unwed mothers.

One of three women aged 15 to 24 who has ever been married conceived her first child prior to marriage, a survey in Mexico City found.[1] Dr. Treviño thinks the rate could be even higher. "Half of the time when there was a pregnancy case, they had to get married, and subsequently the life of these adolescents changed radically."[2]

Many young pregnant women do not get married. Researchers now estimate there are about a quarter million unmarried mothers under age 18 in Mexico.[3] Females age 15 to 19 have almost 400,000 births per year, about one of every six births in Mexico.[4]

"Teenage pregnancy is often the beginning of a very hard life: being kicked out of school, having few (if any) job opportunities, and even raising children alone," reports the International Planned Parenthood Federation/Western Hemisphere Region in its summary of its 1991 activities. "Wom-

en who started having children in their teens have, on average, one and a half times as many children as other women."

To improve such statistics requires more participation in pregnancy prevention by young men. A series of surveys among Latin American youth has shown this to be a challenge. In the Mexico City survey, about half of Mexican males reported having their first premarital sexual experience before age 16, mostly without contraceptive protection. About one of three young men 15 to 24 years old reported using contraception during his first premarital intercourse.[5]

Involving men may be the next important stage of family planning in Mexico, still a young enterprise here. As recently as 1973, advertising and selling contraceptives were prohibited in the Health Code. But the country has made remarkable strides in the past two decades. About half of women of reproductive age now report using contraception.

"Once, even talking about family planning was a sin," reports Cecilia Valdes, who interviewed families in one of the huge slums surrounding Mexico City. "Now, Mexican women are trying to make sure they don't have 10, 11 or 12 children as their mothers did."[6]

Two programs that have begun to focus on young men specifically are the work of people such as Espinosa Garcia through MEXFAM and a series of "Young Men's Clubs" developed by the Center for the Orientation of Adolescents (CORA), a private nonprofit organization based in Mexico City.

"CORA believes boys need information beyond human reproduction and contraception," reports the International Clearinghouse on Adolescent Fertility. "They also need to clarify their own values, set goals for themselves and develop self-confidence."[7] Through eight Young Men's Clubs established in Mexico City, CORA has sought to promote this holistic approach to young men's development through discussions where boys learn from each other.

MEXFAM has approached such issues on many fronts, including the work of trained youngsters and more academic research. In 1990, MEXFAM released a study called "Men, New Machismo, and Family Planning," a report based on interviews with young men by Luis Lenero Otero. One significant conclusion was that young men do not feel close to their fathers and lack a role model for how to relate to responsible sexual behavior.

"The young men are not happy with their own parents, with their fathers especially," says Rodriguez of MEXFAM. "We can work a lot with young men's attitudes. We provoke reflection in young men."

The new machismo, explains Lenero Otero in the report, can be thought of as "a way to consider the relationship between man and woman on the basis of fairness..., on the basis of essential equality." But Lenero Otero shows that this will not be an easy goal to reach. Half of the young men, he found, feel that it is alright to have several girlfriends at the same time, and one-third of those interviewed feel that it is not good when a woman earns more money than a man.

Even so, machismo may be evolving, suggests the MEXFAM work done by teenagers such as the 19-year-old Espinosa Garcia. In the first years of his work, says Espinosa Garcia, more young women came to him for information and contraceptives than men. "But this year things have been changing," he says. "For the first time, more guys than girls have come to me. Machismo is changing, and decisions about contraception are being made more equitably."

— Roberto Brito Lemus

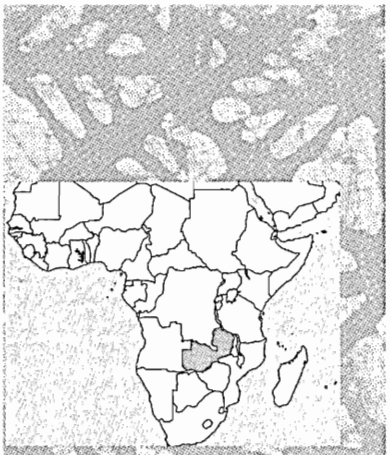
Mr. Brito Lemus is a sociologist at the Centro De Estudios Sociales (Center for Social Studies) in Mexico City. Spanish Network *editor Julia Beamish contributed to this story.*

Footnotes

1. L Morris. Sexual Behavior and Use of Contraception Among Young Adults — What Have We Learned from the Young Adult Reproductive Health Surveys in Latin America? Paper presented at the First Inter-African Conference on Adolescent Health; March 24-27, 1992. Nairobi, Kenya. Table 1.
2. A Zarate Treviño. El sexo y el adolescente. *Nexos*. Abril 1991; 14 (160): 68.
3. Presentation by J Guemes Troncoso at the Primer Simposio Internacional de Educación Sexual, Planificación Familiar y Prevención del Aborto. Published in: Boletín de la Dirección General de Comunicación Social, Secretaría de Salud. 19 de julio de 1990; No. 259.
4. *Health Conditions in the Americas*. Albany, NY: PAHO; 1990.
5. Morris, Tables 4 and 5.
6. *1991 International Planned Parenthood Federation/Western Hemisphere Regional Annual Report*. New York: International Planned Parenthood Federation; 22.
7. Caring About Boys. *Passages*. International Clearinghouse on Adolescent Fertility. 1990: 10 (2): 2-3.

BERYL GOLDBERG

THIS POSTER AT A FAMILY PLANNING CLINIC IN MEXICO CITY ASKS: ARE YOU REALLY MACHO? THEN PLAN YOUR FAMILY!



Men Targeted for Family Planning in Zambia

LUSAKA, Zambia — Joseph Phiri, 43, is a middle class Zambian happily married for 14 years to Astridah, 35. The couple has decided their fifth child, a two-year-old son named Mwale, will be their last. But the decision did not come without debate. Phiri, a personnel officer at Zambia's only fertilizer manufacturing plant, believes he can maintain a slightly larger family. His wife thinks five children are enough.

Years back, Phiri influenced his wife to stop using the pill. After consultations over various family planning methods, they decided to try an intrauterine device (IUD), commonly known in Zambia as the loop. Phiri does not believe in using condoms because he thinks family planning is more of a woman's responsibility.

"The pill was having some painful effects on her," says Phiri from his suburban home in Lusaka, Zambia's capital city. "The loop has brought us no difficulties."

Phiri may be one of few Zambian men against the use of oral contraceptives, commonly called the pill. A study by the Planned Parenthood Association of Zambia (PPAZ) shows that the pill is by far the most popular method of family planning. According to Moffat Mukobotwa, PPAZ senior program officer, at least 80 percent of the women practicing family planning are on the pill.

"Family planning is mainly clinic-based, where promotion of the pill is great," explains Mukobotwa. In urban and rural areas women are exposed to the pill during frequent visits to the antenatal clinic and through friends. Men's role is also important. "The fact that so many women still use the pill goes to show that men are supportive of it," says Mukobotwa.

In this country of about 8 million in southern Africa, about 60 percent of married couples are aware of family planning methods but only about 10 percent use contraception. The PPAZ believes if more men become supportive of family planning, the success rate would grow and the government policy of encouraging small families would be fulfilled. Zambia's population growth rate of 3.4 percent annually is one of the highest in the world.

Among the various methods, the pill and the condom receive the most attention in the country. A recent project by the PPAZ in conjunction with the Ministry of Health discussed contraceptive choice among about 200,000 people of general reproductive age through clinics spread throughout the country. Of these, about two-thirds preferred the pill and another 30 percent selected condoms as the method most desirable.

Only four percent chose all other methods, including IUDs, injectables and spermicides. Virtually no one chose vasectomy. The long-lasting implant, Norplant, is still under experiment at Zambia's largest health institution, the University Teaching Hospital in Lusaka.

The pill seems to be under more public scrutiny not only because it has been around so long but also due to its alleged side effects. Women complain of "too much appetite," irregular periods, dizziness and headaches. This has not reduced the pill's usage to any great extent. In addition, research has shown that the pill is safe for the great majority of women.

Although at least 60 percent of Zambian men support their wives' going for family planning, they are generally reluctant to practice methods directed at their own sex. "Men are reluctant to use the condom because they say it kills the feeling," explains Mukobotwa.

Another factor that may contribute to low condom use as a family planning measure is the attitudes of wives. "I would rather depend on female methods of family planning than let my husband use the condom," says 27-year-old Loveness Mate, who is married with two children and uses the loop. "Condoms are an inconvenience. The act is not normal. They get in the way."

However, men's attitudes toward the condom have changed gradually over the years. The reason is simple — AIDS.

The advent of AIDS has spurred men to use the condom more often. Incessant AIDS messages have spurred them into action. Today, men go to the family planning clinic or the nearest chemist for condoms. Of the estimated 1.5 million sexually active males in Zambia, about 30 percent use condoms.

But there is still one problem. "AIDS has stimulated the use of the condom, but evidence available shows that most of those who use it do so

with their girlfriends or women they do not know," observes Mukobotwa. While AIDS appears to have caused an increase in the use of condoms, it has not necessarily increased the usage of the condom as a family planning measure.

Male sterilization — vasectomy — scares Zambian men. "Most of the men liken sterilization to castration," says Mukobotwa. "They think they would be rendered impotent. Few at all undergo vasectomy." In Zambia, the only men on record for having vasectomies are men of Asian origin.

The traditions of black African men put great importance on virility and macho feelings. Hence, vasectomy will only become acceptable after much education. The Planned Parenthood Association is attempting to provide such information by offering vasectomy through its clinics.

Onward Choolwe, a small-scale rural businessman and father of eight, dreads vasectomy. He would rather his wife be sterilized. "Suppose all my children die, how do I father more?" he asks. "If my wife is sterilized and our children die, I can still marry another woman and have some more." Polygamy is common in rural areas. Choolwe is keen on his wife being sterilized because his large family is already difficult to support.

The PPAZ has targeted men for family planning, both to increase their participation and take advantage of their influence in these matters. The PPAZ promotes all methods of family planning, but some methods have not been well promoted.

The PPAZ has worked heavily along the rail lines in rural areas, where villagers still follow traditional practices thought to prevent pregnancy and lack good information about modern methods. For example, it is not uncommon for rural women to believe that using an IUD would cause their babies to be born with a loop in their hands.

Here, too, it is the women who bear the burden of family planning. Some tie herbs around their waists or insert them in their private parts to prevent pregnancy, but the failure rate is high. Herbs can also be dangerous. "The herbs cause secondary sterility because the concoctions are not well made," says Mukobotwa.

The PPAZ encourages village communities to space children several years apart. It is traditional for husbands and wives to abstain from sex for long periods after the wife gives birth. In their work, family planning experts take maximum advantage of this practice.

Men are generally in control of family planning matters. However, urban women and businesswomen are becoming increasingly influential in these matters. To stimulate male interest, in 1987 PPAZ launched the "male involvement in family planning" campaign and a "motivational campaign for industrial workers" targeted at the working man.

Since 1987, PPAZ officials have held discussions with companies and encouraged them to include family planning services in the clinics at work sites. The concept has been: If women can learn more about family planning at antenatal clinics, why can't men at their workplaces? The Planned Parenthood officials have also been invited occasionally by the labor and social security ministry to give talks at union meetings.

The PPAZ campaign has sponsored male counseling along the rail lines from Ndola, Kitwe and Chingola in the northern copper belt to urban areas in the southern region. One noticeable result of this campaign has been the inclusion of family planning in the company clinic programs by firms along the rail line. The PPAZ has promoted all forms of family planning including the pill, condoms, vasectomy, female sterilization and the diaphragm.

No comprehensive evaluation of the campaign has yet been made, but experts expect male support of family planning to grow, especially with an extremely harsh economic climate acting as a catalyst. As men like Joseph Phiri and Onward Choolwe are realizing, large families are not easy to support.

— *Kondwani Chirambo*

Mr. Chirambo, senior news reporter for the Times of Zambia *in Lusaka, participated in the Anglophone East and Southern African Journalists Workshop sponsored by FHI in 1990 in Kenya.*

KONDWANI CHIRAMBO

ONWARD CHOOLWE, HIS WIFE HELEN AND TWO OF THEIR CHILDREN, SHARON AND KAPEYA.

Men in Bangladesh Play a Role in Family Planning

DHAKA, Bangladesh — "One must not bring a child into the world only to have it go through a life of wants," says Abdul Aziz, a young truck driver in Bangladesh. But finding a way to plan his family has not been easy.

While his wife, Tofura, makes tea in the late afternoon, Aziz explains how embarrassed he felt when he decided to buy oral contraceptives for her from the local drug store. Even with the pills in hand, neither of them knew how Tofura should take them. Finally, Mrs. Aziz gathered enough courage to ask an older woman for advice.

So far, this method of contraception has worked for the Azizes. They have not added any children to the 114 million people in Bangladesh, a small but very densely populated country on the Bay of Bengal mostly surrounded by India.

Another Bangladeshi couple, Ahmed Ali and his wife, Sakina, live in a slum area in Dhaka, the capital. Neither can read or write. "My husband has educated me on birth control," says Sakina. Then she adds, "They say pills harm a woman's appearance." Ali does not let his wife use pills but instead uses condoms. They want only two children.

The decisions by the Azizes and Alis, like those of the other couples interviewed, may indicate that men are becoming more involved in family planning decisions in this conservative, primarily Muslim country. A man's involvement can mean using condoms, having a vasectomy, or, more often, deciding with his wife that she use some other method — and helping to make that possible. In many rural areas, women cannot freely move about to purchase pills, so men must buy them.

A recent study of contraceptive use in Bangladesh indicates that Abdul Aziz and Ahmed Ali are not isolated examples of male involvement. "Contrary to what is generally believed for traditional agricultural societies such as in rural Bangladesh, men and women were found to be making decisions jointly regarding the selection of contraceptives," reports *Progress*, a bulletin of the World Health Organization. "Over 70 percent of women using the pill, IUD [intrauterine device] or condom said that their husbands rather than they themselves went out to obtain these methods. This is remarkable in the case of rural Bangladesh, where men had been generally considered to be indifferent to family planning."[1]

An example of such change is Abdul Karim, a peasant who mostly works as a sharecropper in a village near Dhaka. He takes pride in his wife and in the fact that it was he who convinced her to use birth control. His wife talked to a female family planning volunteer, who taught her how to use the pill. "We are happy with each other," says Karim, as their two children, ages five and three, play nearby.

About one of every four married women under age 50 in Bangladesh uses a modern contraceptive method, a recent national survey shows. Nine percent use oral contraceptives, and 9 percent use female sterilization. Only 2 percent use the condom; 1.7 percent, the IUD; and 1.5 percent, vasectomy.[2]

In this rapidly growing country, the total fertility rate of 4.8 children per woman remains well over the goal of 3.5 Bangladesh has set for 1995.[3] At the same time, changes in couples' attitudes about the desired number of children signal some hope that fertility levels will decrease.

"As recently as 1975, 30 percent of Bangladeshi women, when asked about family size, said it was simply a matter of fate," explains Dr. Halida Akhter, director of the Bangladesh Institute of Research for Promotion of Essential and Reproductive Health and Technologies (BIRPERHT). "Today, only 8 percent think that way. In other words, there has been a revolution in that now couples think about children — they want fewer. The changes are a testimony to the good sense and realism of tens of millions of our families, even though they are often illiterate and most are exceedingly poor."

One new contraceptive method that may help Bangladesh achieve its goal is the long-lasting hormonal implant, Norplant. In recent years, government and non-governmental clinics have introduced it to about 4,500 women, with current plans to reach some 20,000 more. Norplant is highly effective for at least five years and most cost-effective if used for several years rather than a shorter time. Involving the husband in the decision to accept Norplant, including a discussion of side

THIS EXTENDED FAMILY IN BANGLADESH NUMBERS 35.

WORLD BANK

effects and the insertion and removal procedures, seems to be important.

A study of 2,586 potential acceptors of Norplant at 10 family planning clinics in Bangladesh, Haiti, Nepal and Nigeria found a need "for thorough counseling to reduce the apprehensions that women and their husbands may have about the method, such as fear of side effects or of the insertion or removal procedure."[4]

BIRPERHT, in conjunction with FHI, conducted a Norplant counseling study, involving 2,300 husbands, some who were counseled and some who were not. Preliminary findings suggest that the continuation rate at 24 months of use was higher for women whose husbands were counseled compared with women whose husbands were not counseled. Continuation rates are an important measurement because of the initial cost of inserting this device.[5]

The introduction of Norplant is just the latest in a series of efforts made to control population growth by the Bangladeshi government, with international donor help, since the mid-1960s. These efforts have resulted in a gradual change in attitudes among Bangladeshi men regarding family planning.

"I grew up with the teaching that the control of birth and the enjoyment of sex were sins," says Nikhil Saha, a worker in a city school. When Saha saw his elder brother's family sink into progressive poverty with the birth of a new child every year, Saha began to change his mind. In the beginning, Saha's wife, Ratna, was deeply embarrassed talking about birth control with family planning volunteers. But she gradually became more comfortable. Today, after four years of marriage and one child, she counsels her friends and neighbors on using birth control. She uses pills and has not had any side effects.

Traditional religious beliefs still have a strong hold in this rural society. Mohammed Sultan, a fruit vendor in his late 20s, questioned himself: "Isn't family planning an act of God?" Then he quickly added, "But then, if one does not help oneself, what can God do?"

Among rural and less educated couples, discussing family planning and choosing a particular method remain difficult. The wives in the couples who were interviewed for this article generally found it hard, even impolite, to talk about the matter openly with their husbands. This, in turn, put pressure on the husbands to initiate the whole process of inquiry and examination of options and to persuade the wives to participate. This often proved difficult for the men.

A number of the men interviewed complained that the birth control advertisements on the radio, television and in newspapers did not specify how to use such methods as the pill. This limitation hampered both husbands and wives, because it persuaded them birth control is a good idea but did not instruct them in how to proceed.

Communications between husbands and wives, along with information on methods, do seem to be improving. Urban, middle-class couples indicated that they had little difficulty in talking together about family planning and deciding on a course of action. Abdul Hasan Khan, a businessman, married when he and his wife were both in their 30s. They have a two-year-old daughter and are using Norplant. Do they want another child? "Later, maybe," says Farida Khan, herself a college teacher.

The husbands and wives interviewed suggest that sunlight is beginning to pierce this traditional society. "Conservatism runs deep in Bangladeshi society," says Dr. Akhter of BIRPERHT. "But a quiet transformation seems under way. Despite persistent illiteracy and stark poverty, perceptions about family planning are changing. Men are an essential part of that change."

— *Syed Badrul Ahsan*

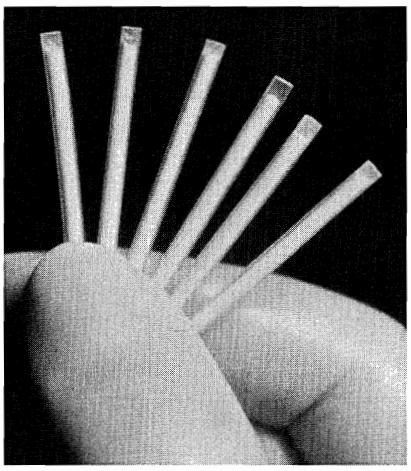
Mr. Ahsan is assistant editor at Morning Sun, *an English daily newspaper in Dhaka, Bangladesh.*

FOOTNOTES

1. Bangladesh: Modern methods are well known but not widely used. *Progress in Human Reproduction Research*. WHO Special Programme of Research, Development and Research Training in Human Reproduction. 1991; No. 19: p. 6.
2. *Bangladesh Contraceptive Prevalence Survey — 1989, Key Results.* Dhaka, Bangladesh: Mitra and Associates. 1989; p. 18, Table 4.1.
3. *Bangladesh — Programme Review and Strategy Development Report.* UNFPA. Prepared in 1990 (n.d.): p. 7.
4. T Kane, G Farr, B Janowitz. Initial Acceptability of Contraceptive Implants in Four Developing Countries. *International Family Planning Perspectives.* 1990; 16 (2): 49.
5. Bangladesh Norplant: Husband counseling preliminary results. FHI memorandum to Dr. Nancy Williamson, April 1992.

Looking for the "Male Pill"

Hormonal drugs, a vaccine and even cottonseed extract offer intriguing avenues for seeking a new male contraceptive, yet perfection remains years away.



THE POPULATION COUNCIL

NORPLANT, AN IMPLANT CONTRACEPTIVE FOR WOMEN, RESEMBLES EXPERIMENTAL IMPLANTS FOR MEN.

For centuries, the condom has been the only reversible contraceptive available for men. While sterilization by vasectomy can be reversed, the operation to restore fertility is expensive, difficult to perform and often fails to work.

Promising ideas for contraceptive drugs for men that would be easy to reverse and safe to use have been under scrutiny worldwide for years, yet remain elusive. Likely candidates for the so-called "male pill" face a variety of technical hurdles, as well as concerns about their appeal to men even if they could be refined for everyday use. While scientists involved in the research are hopeful, they concur that a male contraceptive drug for general use remains years away at best and may not become available until well into the 21st century.

Hormonal drugs and other chemicals that would stop production of sperm make up one approach being explored. Also under way is early work on a vaccine that would target the mechanism of fertilization itself, at least in women and potentially in men. Such a vaccine would not interfere with the production of egg or sperm per se, but would simply prevent sperm from attaching onto the surface of an egg.

Just as chewing gum covering the tip of a key stops it from entering a lock, this type of vaccine would produce antibodies that would coat a sperm surface used in binding sperm and egg. The vaccine would thus block a necessary step in the intricate choreography of conception.

An antifertility vaccine, which might come in pill form, would likely appear first as a woman's contraceptive since it should be easier to neutralize the relatively smaller number of sperm that enter a woman's body. One prediction delays its appearance for general use among men to around the year 2025.[1]

While a hormonal male contraceptive may become generally available by early in the next century, finding hormonal agents that could be taken in pill form, similar to oral contraceptives available for women, seems remote. Hormonal drugs under examination would be destroyed by a man's digestive system if taken orally. Injections and skin implants are among delivery methods thought to be more likely, at least for early forms of this type of male contraceptive drug.

Also under study are natural chemicals, including one derived from cottonseed oil called gossypol. Supporters feel gossypol, which could be taken as a pill, may become the world's first widely used male contraceptive drug. Yet many other scientists reject the possibility because of concerns about the drug's potentially toxic side effects.

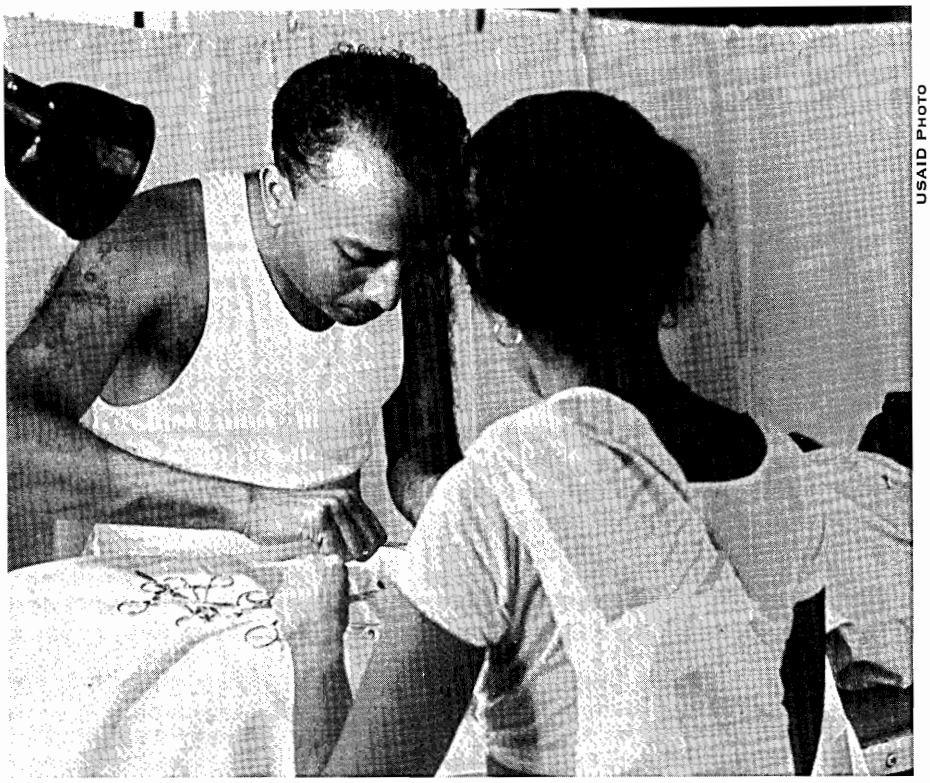
ONLY TAKES ONE

"A man manufactures literally tens of millions of spermatozoa each day," responds Dr. Wayne Bardin, biomedical research director of the New York-based Population Council, when asked why a male contraceptive drug has been so difficult to find. "It takes just one of them to fertilize an egg. The female makes only one egg a month. It's just a much simpler task to find ways of controlling that one egg than the millions and millions of sperm that a man makes."

Because research decisions traditionally have been guided mostly by men, some women's advocacy groups have suggested that undue emphasis is placed on finding new methods that put the burden of contraception on women instead of men. Dr. Laneta Dorflinger, FHI director of regulatory affairs, acknowledges that she has heard the criticism often.

"Yet it is simply a fact that there are many more physiological barriers for coming up with a good male contraceptive," says Dr. Dorflinger, who for years reviewed contraceptive research proposals submitted to the U.S. Agency for International Development. "I've seen few decisions that would have gone differently had a room been filled with women instead of men," she says, adding that rejection of promising avenues for male contraceptive research because of male bias is very rare.

She and other experts say research money available for new male contraceptive methods is scarce for a variety of other reasons. Pharmaceutical companies, for example, are not attracted to difficult



USAID Photo

Doctor performing a vasectomy in an urban family planning clinic in Bombay.

research problems that may not generate lucrative markets even if successful.

Despite the challenges, the Population Council is among several organizations and universities seeking a male contraceptive drug. The council's most promising work involves a hormonal drug that would be administered by implants under a man's skin. Such a device would be similar to Norplant, a recent female contraceptive developed by the council. With Norplant, six matchstick-size capsules are surgically implanted just beneath the skin, typically on the inside of a woman's upper arm. The implants release very low doses of a hormonal drug called levonorgestrel, providing five years of protection against pregnancy.

The male version would be similar in appearance to Norplant, Dr. Bardin says, but with only two capsules. One would release small doses of a hormonal drug, called LHRH 13, to suppress sperm production. The other would ensure a man's sex drive by releasing an androgen, 7 alpha methyl-19-nortestosterone (MENT).

Hormonal contraceptive drugs such as LHRH 13 work by tricking a man's pituitary gland into stopping production of the key hormones necessary for the production of sperm. While that achieves the goal of contraception, it also eliminates natural androgens that give men their sex drive. To overcome the side effect, low doses of a synthetic androgen must accompany hormonal contraceptive drugs in order to maintain sex drive.

"What we are working on is a very fine idea, but it is only an idea at this stage," says Dr. Bardin. Animal tests of the implants have shown complete contraception with no adverse side effects, yet clinical trials in men have not yet begun. Bardin believes general use of a male contraceptive drug in any form, implants or otherwise, is many years away.

Hormonal injections

Searching for the right hormonal agents to use has been a major focus of the World Health Organization (WHO) in Geneva, Switzerland. Injection by hypodermic needle is one way a successful drug might first appear for general use, says Dr. Geoffrey M.H. Waites, manager of the male task force in the WHO Special Programme of Research, Development and Research Training in Human Reproduction. He acknowledges that injections may make a contraceptive less appealing in some cultures.

"We continue to look for something that can be taken orally," Dr. Waites says, referring to such problems as how hormonal drugs would be destroyed by a man's digestive tract before they could take effect. "A pill introduces many new issues to overcome."

Early versions of a successful contraceptive drug, he believes, will probably require injections, perhaps only a few times a year. A 1976 acceptability survey by WHO showed that while most men clearly would prefer pills, many said even monthly injections would be acceptable.

"What we are seeking may not be something a man would want to use for all of his reproductive lifetime," Dr. Waites says. "Yet it may be something very appealing to many men, for example those whose wives have difficulty using female contraceptives."

For people in developing countries, he says, the research has been encouraging. An unexpected finding from a seven-country WHO study on the hormone called testosterone enanthate demonstrated that total suppression of sperm production was nearly universal for Asian men, compared with only about 60 percent total suppression among men from other ethnic groups.

"This relationship may hold for other hormones," he says. "Something that may not be sufficiently effective for men in the United States or Europe might prove to be effective for men of Asian origin."

Testosterone enanthate will not be acceptable as a contraceptive for general use because it requires weekly injections to work. The hormone is making valuable contributions, however, in understanding how hormonal agents of all kinds might work. Research is just beginning on another drug, testosterone buciclate, a long-acting agent so new that it has only been named within the past year. Early results indicate the drug may be effective for three months after each injection, Waites says.

The WHO study on testosterone enanthate demonstrated for the first time that using a hormonal drug to achieve azoospermia, the complete elimination of sperm production, provided a very effective form of contraception. The study also showed that the contraception could be achieved safely and was reversible.[2]

A new phase of WHO's research examines whether men whose sperm production is substantially reduced, but not eliminated entirely, would also have adequate contraceptive protection. Dr. C. Alvin Paulsen heads the

WHO / J. LITTLEWOOD

A COLOMBIAN FATHER SEEKS CONFIDENTIAL ADVICE ON FAMILY PLANNING.

University of Washington portion of the study, which involves 14 sites in nine countries.

Dr. Paulsen says a contraceptive may still be useful even if not 100 percent effective among the men whose sperm production is simply reduced. "We may not achieve zero pregnancies, yet still do better than condoms or other contraceptive barriers," he says.

"When will a male contraceptive be available for public use? I used to say within 10 years, but that was way back in the '70s and we're still working on it," says Dr. Paulsen, a professor of medicine at the Seattle medical center and a veteran of male contraceptive research. "I'd be very happy if development of the so-called male pill were progressing faster. It is indeed a slow process, yet I believe it is progressing."

When boy meets girl

The newer concept of a contraceptive vaccine that would prevent a sperm from attaching to an egg is being explored in many places, including two research centers recently established by U.S. government grants. Scientists from several universities will combine findings and coordinate their efforts, says Dr. John C. Herr, director of one of the centers established at the University of Virginia. The other center is based at the University of Connecticut.

The National Institutes of Health plan to spend US $12 million during the next five years at the Virginia center. "We'll study the sperm surface very extensively, and it is entirely possible that the research will become useful in developing new contraceptive vaccines for men," says Dr. Herr, a reproductive cellular and molecular biologist who is credited with identifying the molecular structure of SP-10, an antigen that may lead to such a vaccine.

"But I should emphasize that we are specifically looking for a contraceptive that would be used by women," he says. He estimates clinical testing even for women would not begin before 1995.

Ideally, Dr. Herr and his colleagues seek an oral vaccine that would neutralize sperm that enter a woman's reproductive tract. The vaccine would help manufacture antibodies that would identify only the specialized sperm surface needed for attachment to the egg. By coating that surface, conception would be blocked.

"Just imagine the difficulty of trying to coat all of the millions of sperm that a man produces in his body. That's a much taller order than trying to intercept the much smaller numbers that get into a woman's Fallopian tubes," Dr. Herr says. "A man might have 10 to the eighth power [100 million] of sperm while only a couple of hundred of them make it into the oviduct. We think that's a better, more practical target."

Among its many attractions, this type of antifertility vaccine would not interfere with the complex hormonal interplay in men or women, thus eliminating undesirable side effects. Less certain, Dr. Herr says, is whether such a vaccine would be easily reversible to restore fertility.

The vaccine approach also offers yet another way to disrupt sperm production in the testes. While an antifertility vaccine for men would be more desireable, since it would not interfere with testicular functions, it may be more difficult to achieve.

Knowledge about the complicated process of conception is advancing on other fronts, offering new avenues for approaching a vaccine. Scientists at the Connecticut campus and the University of California at San Francisco reported this year, for example, that the egg and sperm surrender to one another using a two-step process that closely resembles the way a virus infects a cell. Their findings about the specific molecular structure for the sperm surface protein, called PH-30, bring valuable insights to the search for a vaccine.[3]

The gospel of gossypol

Yet another approach to male contraception could offer a usable drug within only a matter of years, says one of its chief proponents, Dr. Sheldon J. Segal. Recently retired as director of population sciences for the Rockefeller Foundation of New York, Dr. Segal believes China may be close to perfecting a gossypol contraceptive for general use in that country. The natural chemical, found in cottonseed oil, was linked in the 1970s with infertility and impotence among Chinese men and with amenorrhea among women who ate food processed with the oil.

"Mind you, I'm not saying people shouldn't go ahead and search for these other forms of contraceptives," Dr. Segal says. "But I am saying that gossypol is the most advanced method, and that it has the advantage of not suppressing testicular hormone production. It simply suppresses sperm production."

Because hormonal drugs must be supplemented with androgens to maintain sex drive, Dr. Segal believes gossypol may eventually be viewed as a more desirable approach. "Androgen is just another way of saying anabolic steroid. You'd be giving a man the same stuff that we kick kids off the Olympics team for using. You have to be

very, very careful administering androgens to assure that you stay within the normal ranges." Gossypol avoids the problem by not interfering with the hormonal process.

The major criticism concerns the chemical's toxicity, especially for the contention that it can cause potassium depletion in some men. Such a depletion can lead to dangerous heart beat irregularities (arrhythmias). Research is seeking a non-toxic dose of the chemical, Dr. Segal says, yet several other scientists note that the search has been under way for many years without success.

Backed by the Rockefeller Foundation, clinical trials on a low dose of gossypol as a contraceptive will begin on 300 men in several countries this year, Dr. Segal says. Scientists in Austria, China, Cuba, Brazil, Nigeria and the Dominican Republic are expected to take part. The dose being studied does not cause potassium depletion, he says. "We're closer to having a viable contraceptive than many people seem to think," says Dr. Segal, who adds that the Chinese could begin widespread use of the drug by the mid-1990s, provided all goes well. "Gossypol is far from a curio," he says.

Whether the drug offers men a chance to return to fertility is another criticism. Only about 80 percent of men who have used gossypol in previous studies have had fertility restored. Dr. Segal believes that should still make the drug an important contraceptive.

"It's an attractive alternative to vasectomy, where reversal prospects are much more remote," he says. "But we should be frank with any man who uses this method and say to him that it could be irreversible."

Dr. Segal believes that one reason progress with gossypol has been slow in coming is that the natural chemical can not be patented. Consequently, there is little interest among pharmaceutical companies to pursue the research.

"That's why the work of organizations like the Rockefeller Foundation is absolutely essential if we are to find a male pill," Dr. Segal says. "These organizations are not interested in bottom-line profits."

—Nash Herndon

Footnotes

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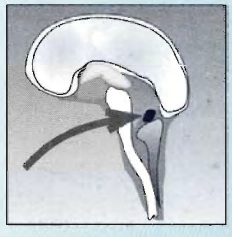
2. WHO Task Force on Methods for the Regulation of Male Fertility. Contraceptive efficacy of testosterone-induced azoospermia in normal men. *Lancet*. 1990; 336 (8721): 955-59.
3. CP Blobel, TG Wolfsberg, CW Turck, DG Myles, P Primakoff, JM White. A potential fusion peptide and an integrin ligand domain in a protein active in sperm-egg fusion. *Nature*. 1992; 356 (6366): 248-52.

Two Approaches for Finding a Male Contraceptive Drug

Halting sperm production

Hormonal contraceptives



Two hormones secreted by the pituitary gland at the base of the brain are needed to produce spermatozoa. These natural hormones, or gonadotrophins, are called the follicle stimulating hormone (FSH) and luteinizing hormone (LH). Their secretion is regulated by a hormone from the hypothalmic region of the brain called the gonadotrophin releasing hormone (GnRH).

The body carefully controls the amount of GnRH it releases, curtailing GnRH when hormonal levels rise. By introducing a steroid hormone, such as testosterone, production of natural hormones shuts down and sperm are not produced. One type of GnRH is called the luteinizing-hormone releasing hormone (LHRH). Some drugs, called LHRH analogues, provide another way to curtail natural hormonal production. LHRH analogues are also being developed to treat prostate cancer.

Drawbacks: Since hormonal drugs under study also decrease testosterone production as they shut down sperm production, they must be combined with a synthetic androgen to maintain sexual drive. They can not be taken in pill form, requiring injections or other delivery methods. Current LHRH analogues are expensive.

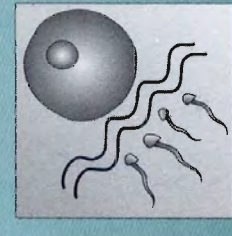
Chemical interference

Some natural chemicals, like gossypol derived from cottonseed oil, have been found to cause sterility without upsetting hormonal cycles. Work is also under way in China and Thailand on *tripterigium wilfordii*, an herbal medicine used to treat skin conditions that has been linked with infertility.

Drawbacks: Gossypol may cause a dangerous depletion of potassium in some men, which can lead to heart problems. Research seeks a non-toxic version. The return to fertility in some men has been quite delayed.

Blocking conception

Anti-fertility vaccine



Using the body's immune system, a contraceptive vaccine against sperm would include an antigen (a specific protein) on sperm that allows sperm to attach onto the surface of an egg. The vaccine would stimulate the body's production of antibodies that would coat the protein surface, thus blocking a key step needed to fertilize an egg.

Drawbacks: Such a vaccine is many years away and would be administered to women, at least initially. A male version would be desireable, but very difficult to achieve. A vaccine approach that would disrupt sperm production may be more feasible for men.

AIDS Puts Condoms in Spotlight

While use of condoms is increasing dramatically with the AIDS epidemic, its appeal as a male contraceptive remains less certain.

Ten years into the AIDS crisis, the number of condoms being distributed worldwide has increased dramatically. This vast increase in availability raises an important policy question for family planning programs around the world. Does the attention on condoms provide a means of getting men more involved in family planning?

The answer to this question may vary among countries, depending upon the rate of HIV infection and the type of national family planning system. But there are some similar issues that all countries are now beginning to explore regarding condom use and male involvement in family planning.

Family planning programs have not traditionally targeted their services toward men or, for the most part, promoted condoms as a family planning method. As men are becoming more willing to use condoms for disease prevention, family planning programs may have an opportunity to promote condoms more aggressively for contraceptive purposes.

"In a fundamental way, AIDS has changed how we view contraception," says Dr. Nancy Williamson, director of FHI's Program Evaluation Division. "In addition to worrying about unwanted pregnancy, many women need to be concerned about sexually transmitted diseases, as do men. Condoms are being heavily promoted for AIDS prevention and hence are increasingly available. This provides an unprecedented opportunity for making condoms available in a family planning setting."

"IN A FUNDAMENTAL WAY, AIDS HAS CHANGED HOW WE VIEW CONTRACEPTION."

DR. NANCY WILLIAMSON

Few scientific studies have examined how condom use in developing countries has changed since the onset of AIDS. Also, the demographic literature typically asks women about their use of contraceptive methods, including condoms, to delay or avoid pregnancy, and does not ask about condom use for disease prevention.[1]

"With the spread of AIDS, we have a good deal of anecdotal evidence that condoms are being promoted as both a contraceptive and a prophylactic," says Dr. Tim Johnson, who tracks condom use overseas for the U.S. Centers for Disease Control. "We believe that there has been some increase in use for contraception, but we lack adequate documentation of the magnitude of this change."

Interviews with regional program managers in developing countries indicate that some family planning clinics are putting more effort into promoting condoms, but whether clients are requesting them primarily for AIDS prevention or contraception has not been documented.

"AIDS has certainly triggered more condom use, and indirectly I think, more family planning involvement by men," says Dr. Cynthia Green, who reviewed the literature on men and family planning for the World Health Organization/Global Programme on AIDS (WHO/GPA). "The promotion of condoms for AIDS prevention elevates the discussion of condoms so that they are not a taboo topic. That gets more couples talking about sexual behavior, which may open the door to more male involvement in family planning."

The condom offers several advantages as a contraceptive. It is the only modern method of male contraception providing temporary protection, allowing men to take an active role in family planning without using a permanent method, vasectomy. It has virtually no side effects and does not require a medical delivery system. Perhaps most important, it is the only contraceptive that offers protection against sexual transmission of HIV, which causes AIDS.

Experts consider condoms to be a highly effective contraceptive if properly used. They are often used inconsistently and improperly, however, leading to higher rates of failure than other contraceptives.[2]

With the onset of AIDS, the public health community has promoted condoms as a primary

weapon to prevent the transmission of HIV. The U.S. Agency for International Development (A.I.D.) reports that shipments of condoms to the developing world have skyrocketed. In seven years, the number of condoms A.I.D. shipped to sub-Saharan Africa per year jumped 17-fold, from 9 million in 1984 to 154 million in 1991. During the same period, the yearly figure of A.I.D. shipments to Latin America and the Caribbean tripled (31 million to 93 million) and to Asia more than doubled (231 million to 499 million).[3]

Last year A.I.D., by far the largest donor of subsidized condoms in the world, delivered about 820 million condoms overseas. The United Nations Population Fund (UNFPA) and the International Planned Parenthood Federation (IPPF) shipped the next largest totals, about 100 million and 20 million, respectively. The World Bank and WHO/GPA are also supporting the purchase of condoms.

Data on the number of condoms shipped do not necessarily reflect the number of condoms used, nor do they indicate what they are used for. Mary Beth Weinberger of the United Nations Population Division has analyzed condom use for contraceptive purposes, using Demographic and Health Surveys (DHS) and other national surveys conducted around the world.

"In most of the less developed regions..., condoms account for 3 percent to 4 percent of contraceptive practice," Weinberger explains. "In sub-Saharan Africa, less than 1 percent of couples currently use condoms within marriage."[4] Further, she found that for those countries where surveys have also been done in earlier years, the use of condoms as a contraceptive has not increased significantly.

However, these surveys probably do not reflect the full impact of current condom use for pregnancy prevention. Many of the latest DHS surveys were done in the late 1980s, prior to major national efforts to promote condoms for AIDS prevention. In addition, such surveys depend primarily on answers from wives regarding condom use by married couples for family planning. Thus, the data are probably biased by the reliance on female respondents, who tend to report lower use rates of male methods than do men.[5] Also, these national surveys are unlikely to get good data on condoms used in extramarital relations, even though such use affects pregnancy prevention.

"Special surveys inquiring about condom use in all sexual relationships are needed," adds Weinberger.

In addition to such research problems to solve, there are programmatic issues to address. "Condoms have not been favored by most family planning providers due to concerns about condom effectiveness, acceptability, consistent and correct use, breakage, logistics and cost," says Dr. Williamson of FHI. "Promoting condoms aggressively requires a major reorientation for many family planning programs."

Condoms have not been popular in many cases, for a variety of reasons. "People have generally doubted [the condom's] reliability, dislike the idea of interrupting lovemaking to put them on, believe that they reduce sexual pleasure, or simply dismiss them as an embarrassing item. In many cultures, their association with illicit sex adds to these negative perceptions," says Dr. Axel Mundigo, of the Special Programme of Research, Development and Research Training in Human Reproduction, World Health Organization.[6]

The association of condoms with sexually transmitted diseases and illicit sex is heightened by the threat of AIDS. Some family planning program managers worry that married couples will be reluctant to use condoms for family planning if the device is promoted primarily for prevention of AIDS and other sexually transmitted diseases. Consequently, some social marketing programs have focused

GISELE WULFSOHN / IMPACT VISUALS

SOUTH AFRICAN MEN RECEIVE CONDOM SAMPLES AFTER A PUBLIC AIDS PREVENTION DEMONSTRATION.

CONDOMS ARE AMONG ITEMS AVAILABLE AT A MEXICO CITY DRUG STORE.

BERYL GOLDBERG

on promoting condoms as a convenient, safe, contraceptive method for married couples.

At least one study has found that an increasing awareness of the condom's role in AIDS prevention has the potential for improving the image of condoms for contraception. John Stover of The Futures Group and Mario Bravo, former director of the Mexican National Committee for Investigation and Control of AIDS, surveyed 1,300 males and 1,300 females in urban Mexico in 1988, following a national AIDS information campaign.

"An increasing awareness of the condom's role in AIDS prevention...did not seem to lead to a worsening of the condom's image as a family planning method," the report concludes. "In fact, the AIDS messages improved knowledge about the condom as a contraceptive method."[7]

Improvements in the technology involved in making condoms could also affect various reservations about condoms. FHI is currently conducting such research and hopes to find a plastic material that can endure severe storage conditions without deteriorating, perform more reliably during use than a latex condom and provide greater consumer satisfaction.

MANAGERS REPORT MIXED TRENDS

Recent interviews with four program managers in Asia, Latin America and Africa provide additional insights on trends in condom use. In each of these countries, there is a high incidence of HIV infection relative to surrounding countries, and condoms have been promoted aggressively in recent years to reduce the spread of the virus.

Among these four countries, only in Uganda was condom use clearly increasing for both contraceptive use and protection against sexually transmitted disease (STD). Uganda has one of the highest HIV infection rates in the world.

"In Uganda, the use of condoms is on the increase both as a contraceptive and for protection against AIDS and STDs," says Pauline Muhuhu, director of the regional office for Anglophone Africa for the Program for International Training in Health (INTRAH). "Clinics in Kampala [Uganda's capital] specifically promote the use of condoms as a back-up contraceptive to ensure protection for clients initiating other contraceptive methods and for those changing methods."

INTRAH recently conducted training programs for Ministry of Health personnel working in family planning clinics in Uganda. The training was designed to enhance clinical skills in family planning, including use of condoms. A follow-up survey at four Kampala clinics found that the average number of new acceptors of condoms as a family planning method by the mostly female clientele had increased from 91 to 117 per month, a 29 percent increase.

In another country with a growing AIDS problem, Brazil, the data are not as clear, although condoms are being promoted for contraception and AIDS prevention. BEMFAM, the major nonprofit family planning agency in Brazil, has a nationwide network of clinics. Through these clinics, BEMFAM has expanded its services from family planning into STD and AIDS prevention work and now actively promotes condoms for both family planning and AIDS prevention.

"We are promoting condoms both for STD/HIV protection and for family planning," says Dr. Ney Costa, medical director of BEMFAM. He reports that the agency distributed about 2 million condoms in 1984, prior to widespread knowledge about AIDS. In 1991, that figure had risen to 14 million. "Unfortunately, we have no way to break out for which purpose they are being purchased."

Two countries with aggressive family planning programs and a growing problem of HIV infection are Zimbabwe and Thailand. But condoms do not appear to be gaining popularity as a contraceptive in either country.

"Since 1989, condom use has doubled in Zimbabwe," says Peter Halpert, regional director for Southern and Eastern Africa, Family Planning Logistics Management Project, John Snow Inc. "I don't have any numbers on the end use of condoms, but I can assure you that virtually all of the increased usage is for AIDS prevention."

A 1988 study of 512 married men in Zimbabwe indicated that virtually all of them had heard of family planning.[8] The 1988 nationwide Demographic and Health Survey

in Zimbabwe found that only 1.2 percent of married women reported using condoms for family planning, with the pill being by far the most popular method, used by 31 percent of married women.[9]

Distribution of imported contraceptives in Zimbabwe is carried out exclusively by the Zimbabwe National Family Planning Council (ZNFPC) through its own clinics and clinics run by the Ministry of Health. Therefore, data on contraceptive issues are considered very reliable. The number of condoms provided by ZNFPC rose significantly in just two years, from 18 million in 1989 to nearly 30 million in 1991. The program estimates that it will distribute 38 million condoms in 1992.

"There are posters in all the clinics promoting the condom as an AIDS prevention," Halpert says. "It is not really being promoted as a family planning method either by the staff or in printed materials."

In Thailand, recent studies indicate that some 65 percent of married couples use contraceptives, primarily injectables, pills and IUDs. "Condoms are not used for contraception much at all in Thailand — either before or after the advent of AIDS," says Tony Bennett, Thailand resident advisor, AIDSCAP/FHI. "The condom in Thailand is associated almost exclusively with prostitution and STD prevention. Only about 1 percent of married couples use condoms for family planning. We have less hard data on the use of condoms in non-commercial, non-marital relationships, but we know it is low."

As the AIDS era lengthens, condoms will surely reach into more parts of the world in record numbers. This may cause an increase in their popularity as a contraceptive method in developing countries. Or at the least, it will be one factor among many prompting men to think about their role in pregnancy and family planning in new ways.

"The challenge we face is to develop an integrated approach to ... three great problems that face us at the end of the 20th century — family planning, HIV prevention and sexually transmitted disease control," write Dr. Malcolm Potts, president emeritus of FHI, and Dr. Roger Short of Monash University in Australia. "Condoms hold the key to all three — and underline their interrelatedness."[10]

— John Manuel

Mr. Manuel is a freelance journalist. For Network *12 (3) he reported on issues affecting condom reliability.*

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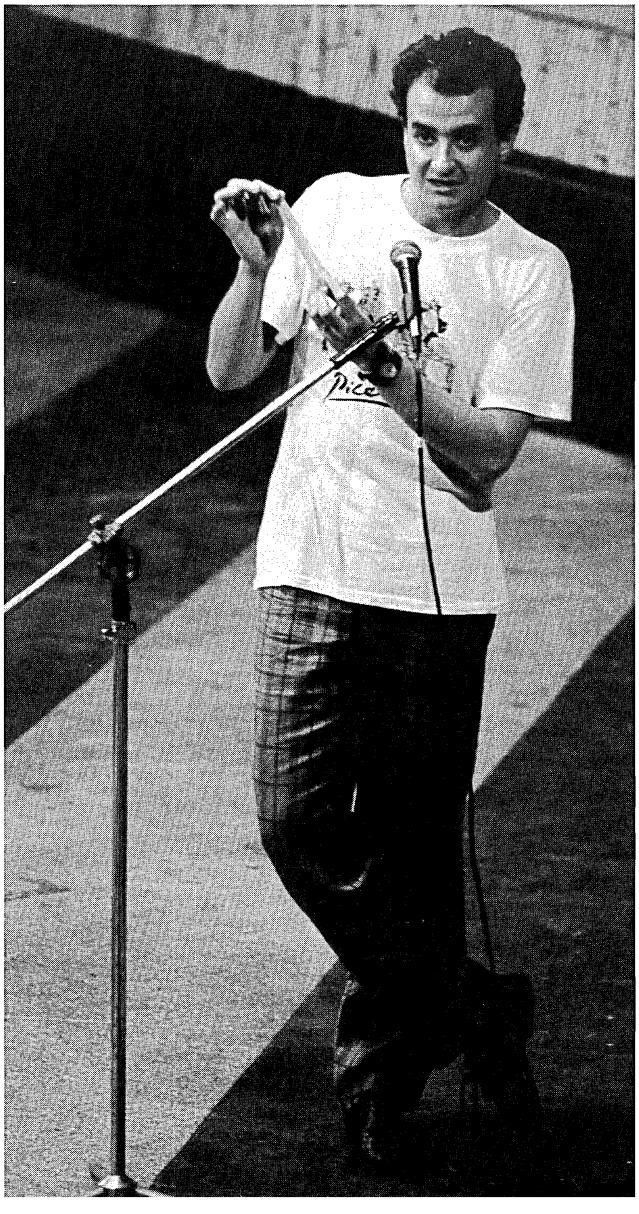


Katherine McGlynn / Impact Visuals

AIDS-prevention educator talks about using condoms to employees in Brazil.

Making Vasectomy Attractive

New surgical methods, advertising and even simple word of mouth encourage men to consider vasectomy.

Two animated hearts snuggle in a Brazilian television ad as wedding music plays. A parade of bouncing baby hearts soon arrives, the predictable outcome of their romance.

When the male valentine next approaches his object of desire, the female plays coy. She does not want any more children. Only when the male heart returns with two distinctive slits upon his anatomy, marks symbolizing a vasectomy, does the female heart choose to cuddle once again.

"Vasectomy, an act of love" says a voice in the 1989 television ad, part of a publicity campaign by Promoção de Paternidade Responsavel (Pro-Pater), a private, non-profit Brazilian family planning organization that promotes vasectomy. The television message ends by listing clinics and telephone numbers where men may obtain more information.

Advertising has become a useful tool for family planners trying to encourage male sterilization by vasectomy. Refinements in the procedure itself are also attracting more men, especially the option of the so-called "no-scalpel" technique developed in China. No-scalpel vasectomy offers psychological reassurance for men by replacing the traditional incisions of a scalpel with a tiny puncture performed by a tool resembling manicure scissors. An even newer concept under study in China would bypass surgery entirely, by injecting silicone beneath the skin instead of puncturing or cutting the skin.

Worldwide, 42 million married couples of reproductive age already depend upon vasectomy as their method of contraception, about 5 percent of all such couples, says Jeffrey M. Spieler, a senior biomedical research advisor for the U.S. Agency for International Development (A.I.D.) in Washington. Yet a glimpse of the world by region shows acceptance of male sterilization is mixed. While vasectomy makes up 9 percent of all contraception methods used by married couples in eastern Asian countries and 6 percent for the rest of Asia, it accounts for only 1 percent or less in Latin America and Africa, says Spieler.

"Men will get more involved with contraception, if they are encouraged to do so," Spieler says. "We need to pay more attention to what I call 'software issues,' the various aspects surrounding how we deliver the hardware of technology, how we make it attractive enough for men to get involved."

If the role of men in family planning is to expand significantly in the near future, that will mean greater use of vasectomy, Spieler and other experts say. New methods of male contraception are many years away from perfection. Condoms and the age-old practices of abstinence or withdrawal are the only other contraceptive methods available for men.

PRO-PATER USES ANIMATED HEARTS TO ENCOURAGE BRAZILIAN MEN TO CONSIDER VASECTOMY.

PRO-PATER

Word of mouth

Advertising is one way to encourage greater use of vasectomy. Another is simple word of mouth. As more men choose vasectomy, its acceptance among others will be easier to achieve, according to Dr. Marcos Paulo P. de Castro, director of Pro-Pater, which has used magazine and billboard advertising as well as its brief television campaign.

"Our experience shows us that always — independently of any mass media campaign — the principal influence on vasectomy acceptance is the testimony of a friend or relative who has undergone the surgery, is very satisfied with it, and refers the good services of our clinic," he says.

The television campaign followed a 1985 print advertising effort by Pro-Pater, when ads ran for 10 weeks in local editions of prominent national magazines. During the weeks the ads were published, Pro-Pater clinics nearly doubled the number of vasectomies performed — to about 20 a day from an average of about 11 daily before the ads. While vasectomies declined after advertising stopped, the

numbers continued at higher levels than before the advertising campaign.[1]

One such ad, showing a pregnant man, asks this question: "And if men had children?" Another shows a man and woman about to kiss. It says: "It's up to her to avoid pregnancy, only her."

Such messages may strike a responsive chord with the typical man who seeks a vasectomy. A key reason many men cite for having a vasectomy is to remove the burden of family planning from their wives, says Deborah S. Gates of FHI's clinical trials division. Typical vasectomy patients are married men who already have children, she says.

She agrees with Dr. de Castro's assessment, that comments from friends and neighbors play an important role in a man's decision to seek vasectomy. "More men are coming in because vasectomy is becoming less mysterious. They know more people who have had it, they can see it is harmless, that it is not emasculating," Gates says. "Their neighbor has had one, their brother-in-law has had one — so they know somebody who has had a vasectomy and that person was satisfied with it."

Gates is evaluating vasectomy results among 1,350 men in Brazil, Indonesia, Sri Lanka, Thailand and Guatemala. A similar FHI study of 1,530 vasectomy patients is being planned in Mexico in collaboration with the Association for Voluntary Surgical Contraception (AVSC), and the Mexican Social Security Institute (IMSS).

Strides in Latin America

"There's no question that Pro-Pater in Brazil, and an organization called PROFAMILIA in Colombia, have taken tremendous strides in educating men about the option of vasectomy," says Sara Warren of AVSC, a New York-based organization. Others mention the successful work of APROFAM in Guatemala in promoting vasectomy.

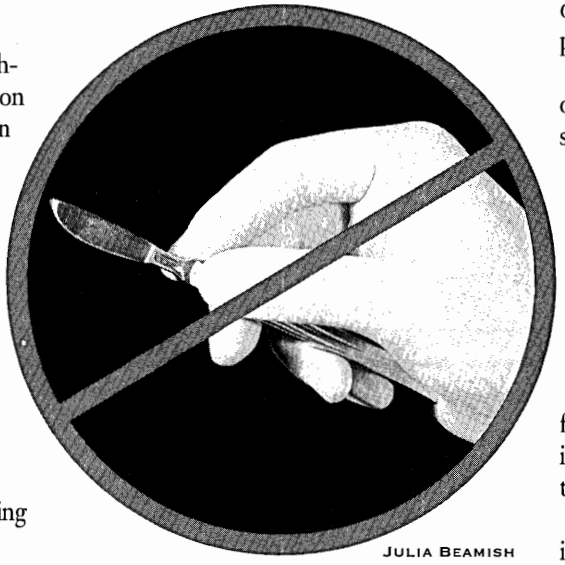
"There is the machismo issue in Central America and South America. While there are different views on that, one prevailing thought has been that many family planning efforts are geared toward the woman instead of the man because of machismo," says Warren, who works closely with organizations like Pro-Pater.

The Pro-Pater advertising, she says, demonstrates that men can be receptive to the idea of vasectomy even in cultures where males may resist taking responsibility for family planning. About 10,000 vasectomies were performed last year through programs assisted by AVSC in Brazil, Colombia and Mexico.

"The big problem with advertising is not whether it's effective. The big problem is that it's very, very expensive," she says.

The television ads, for example, cost US $300,000. Through Johns Hopkins University's Center for Communications Programs, A.I.D. helped finance the campaign, which targeted several Brazilian cities with six weeks of advertising.

From a financial perspective, print advertising may be justifiable, according to one study. Even a year after magazine advertising had ceased, some callers seeking information from vasectomy clinics continued to mention the ads as their referral source. By assigning



Julia Beamish

magazine advertising costs only to those additional vasectomies performed because of the ads, the study concluded that it cost US $13 in advertising to attract each new vasectomy client. Eliminating less-productive magazines from the campaign would have lowered the cost to US $8.[2] By contrast, a patient typically pays US $150 for a vasectomy in Brazil.

Knowledge about vasectomy, the nature of vasectomy procedures and where to get one clearly increased in São Paulo with advertising, says Dr. Leo Morris of the Division of Reproductive Health, U.S. Centers for Disease Control in Atlanta. He provided technical assistance for household surveys conducted before and after Pro-Pater's television advertising in the Brazilian cities of São Paulo and Salvador. The number of vasectomies performed at clinics listed in the ads went up, he says, but the overall impact among all men in each city is less certain.

"In São Paulo, there was a significant increase in the proportion of men with knowledge of vasectomy and the nature of vasectomy procedures," he says. Results from Salvador, however, did not show a significant increase in the overall knowledge of vasectomies, even though there was an increase in the number of vasectomies performed at advertised clinics.

No scalpel, no fear

One reason more men may trust vasectomy is the advent in recent years of the "no-scalpel" technique developed in 1974 by Li Shun-Quiang in China. An estimated nine million Chinese men have already undergone the procedure, but its use elsewhere in the world is relatively new.

Developed as a way of increasing acceptability of vasectomy by eliminating the fear of incision, the no-scalpel technique provides other benefits. Speed and fewer medical complications are among them.

In a traditional vasectomy, doctors make one or two incisions with a scalpel in the scrotum, cuts about a centimeter long, to gain access to the two thin tubes through which sperm travel. The tubes, called vasa deferentia, are cut and sealed under either approach.

No-scalpel vasectomy, however, uses a specially designed surgical clamp to pinch and encircle the vasa just beneath the scrotal skin. A tiny puncture from a sharp-tipped forceps then pierces the skin. The forceps are inserted to stretch the small opening, exposing the vasa for cutting.

According to AVSC, which trains doctors in the technique, the new method takes only about 10 minutes to cut and tie the tubes, compared with about 15 minutes for the traditional method of using a scalpel. At an annual festival held in Thailand on the king's birthday, free vasectomies typically are offered in recent years. During the Dec. 5, 1987 event, a government building's auditorium was converted into operating rooms where both methods of vasectomy were performed on more than 1,200 men. On average, a physician could perform 57 no-scalpel vasectomies during the day compared with only 33 for the traditional approach. Monitoring patients in the weeks that followed showed 19 men developed complications, but only three of those resulted from the no-scalpel approach.[3]

Because there is less injury to tissue with the tiny no-scalpel puncture, there are fewer complications like hematoma, a collection of blood under the skin. There is less risk of infection because the opening into the scrotum is so small. Stitches are not needed, and patient recovery also appears to be faster.

"As far as training doctors goes, we are very much a 'no-scalpel' organization," says Pam Harper of AVSC, which in 1985 spon-

sored a visit of surgeons to China to observe and evaluate the method. In 1988, AVSC began introducing the no-scalpel method to programs in Brazil, Colombia and Guatemala. It trained six physicians from the three countries that year. The organization has also promoted no-scalpel vasectomy among doctors in Asian and African countries, as well as in the United States. The procedure is performed in about 20 countries worldwide. In Mexico, for example, where doctors were trained in the no-scalpel method in 1989, vasectomies performed in Mexico City increased substantially, from about 1,500 a year in 1988 and 1989 to nearly 2,500 in 1990.[4]

Long-term health concerns

Fear of surgery is a major obstacle in the minds of many men, but not the only one. The Brazilian survey of men's attitudes during the television ad campaign revealed other stumbling blocks, including fear of side effects and concerns that men may change their minds afterwards and want another child.

Vasectomy is widely regarded as one of the safest of all surgical procedures and one of the most effective contraceptive methods. Questions have been raised, however, about the potential for long-term health problems including testicular cancer, prostate cancer and myocardial infarction, a form of heart disease.

Regarding myocardial infarction, about 20 epidemiological studies have been performed, yet none has found any association between vasectomy and circulatory system diseases, says Dr. I-Cheng Chi of FHI's clinical trials division. Dr. Chi was the principal investigator in two such studies conducted by FHI in South Korea.[5]

Two recent studies on the relationship between vasectomy and prostate cancer suggest an association, although most epidemiologists believe no relationship exists. Dr. Chi believes more study would be useful because of the relatively common occurrence of prostate cancer, especially among western males.

Another study has raised very tenuously the question of whether vasectomy may increase a man's risk of getting testicular cancer. That type of cancer is so rare that designing a meaningful epidemiological study would be a difficult task, Dr. Chi says.

A recent comprehensive study in England of more than 13,000 men who had undergone vasectomies could find no evidence linking vasectomy and any of the three diseases.[6]

Future improvements

Vasectomy should be considered permanent, although some success in restoring fertility has been achieved. Reversal operations are expensive, involve hospital stays and don't always work. Only a few medical centers are capable of the refined microsurgical techniques needed, making prospects extremely remote for getting a reversal in most developing countries, at least among men with modest incomes.

Recent work with a microsurgical laser to assist in vasectomy reversal shows promising results, yet only one in three men who underwent the reversal within 10 years of their vasectomy achieved pregnancy with their wives.[7]

How the vasa are actually cut is important with respect to a reversal. Cutting the straight portion of the vasa in the upper portion of the scrotum, away from the convoluted portion of the tubes, improves prospects that a reversal will work.[8]

A device called the Shug, with silicone plugs that are inserted into the vasa through punctures, instead of cutting the tubes entirely, may also improve reversal prospects. Tissue physiology seems to remain in better shape and be more receptive of reconnective surgery.

Other ideas that could make vasectomy even more appealing and possibly more reversible include injections of polyurethane or silicone directly into the vasa with a hypodermic needle, a procedure that eliminates surgery. The liquid material quickly hardens into a solid plug under the process, which is under study in China. The procedure is more difficult to perform, however, than conventional or no-scalpel methods. As concerns have arisen about a chemical in polyurethane that has been linked with cancer, scientists have shifted attention to silicone injections. More than 100,000 Chinese men have undergone the procedure, with 98 percent achieving sterilization.[9]

A new instrument called a Vasocclude is being developed by the Population Council based in New York. The instrument would be used to apply clips onto the vasa directly inside the scrotum, without having to remove the vasa for cutting. A surgical cut or puncture would still be needed to gain access to the vasa. The Population Council is negotiating with a U.S. manufacturer for production of the device, which could become widely used on men by 1996.[10]

—Nash Herndon

PRO-PATER

THIS ADVERTISEMENT, RUN IN BRAZILIAN MAGAZINES, APPEALS TO MEN TO THINK ABOUT FAMILY PLANNING.

Footnotes

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Resources

FHI FAMILY PLANNING SERVICE GUIDELINES

Catalogue of Family Planning Service Delivery Guidelines is available from FHI for family planning programs overseas. The 300-page report was developed by FHI researchers in collaboration with the Family Planning Services Division in the Office of Population at A.I.D. This inventory of current policies and procedures, developed by several international health and family planning organizations, may be useful to organizations that would like to develop their own guidelines and for policymakers and researchers concerned about quality of care issues.

The catalogue was designed to encourage service delivery guidelines that are technically accurate, easy to use and consistent, according to Dr. Karen Hardee-Cleaveland, an FHI senior researcher who co-authored the publication. It includes tables of 11 contraceptive methods and their respective guidelines.

Guidelines include such topics as contraindications for use of oral contraceptives, recommended follow-up visit schedules for IUDs, and side effects associated with various contraceptive methods. Sources for the guidelines are: International Planned Parenthood Federation, Family Planning International Assistance, the World Health Organization, *Contraceptive Technology: International Edition 1989*, the Association for Voluntary Surgical Contraception, the Enterprise Project/The Family Planning Service Expansion and Technical Support Project (John Snow Inc.), Pathfinder International and SOMARC (Futures Group).

For more information, please contact: Dr. Karen Hardee-Cleaveland, Family Health International, P.O. Box 13950, Research Triangle Park, NC 27709 USA.

FHI MONOGRAPH OFFERS REASSURING DATA ON IUD USE

An FHI monograph, *Long-term IUD Use in Ljubljana, Yugoslavia*, provides data from one of the world's largest retrospective studies ever conducted on IUD use. Written by Drs. Lidija Andolsek and Mateja Kozuh-Novak, the 82-page book summarizes the work at one family planning institution where 10,000 IUD insertions were performed over a 15-year period.

Questions concerning the safety of long-term use of IUDs have been raised in recent years. Results of this analysis of patient records at the University Medical Centre in Ljubljana provide substantial evidence that the IUD is an appropriate long-term method of contraception for many women. The types of IUDs included in the study were the Lippes Loop and two other devices not widely available around the world (Margulies Spiral and the metal M-device).

This monograph is available free upon request from: Debbie Wade, Publications Assistant, FHI, P.O. Box 13950, Research Triangle Park, NC 27709 USA.

PLEASE RETURN *NETWORK* SURVEY

Thank you to all who have completed and returned the questionnaire that was included in the last issue of *Network*. Returning the form with your mailing label attached will ensure that your name remains on our mailing list. Please do not remove the label.

To get a new survey form or to send one in, contact: Ms. Debbie Wade, Publications Assistant, Family Health International, P.O. Box 13950, Research Triangle Park, NC 27709 USA.

NEW PUBLICATION TO IMPROVE MANAGERIAL SKILLS FOR FAMILY PLANNING STAFF

A new bimonthly publication, *The Family Planning Manager*, is designed to help family planning clinic managers and supervisors improve their efficiency.

The Family Planning Manager, a 12-page newsletter, focuses on a specific topic each issue and offers practical management strategies. The first issue examines how to reduce waiting time at clinics. Each issue contains tips and techniques to help diagnose management problems and improve service delivery. A case scenario provides supervisors and trainers with educational material for staff development.

To receive this free publication, write: Family Planning Management Development, Management Sciences for Health, 400 Centre Street, Newton, MA 02158 USA or fax: 617-965-2208.

RESOURCES FROM THE ASSOCIATION FOR VOLUNTARY SURGICAL CONTRACEPTION

Family Planning Counseling and Voluntary Sterilization: A Guide for Counselors, published by the Association for Voluntary Surgical Contraception (AVSC) in 1992, provides information on the responsibilities of a family planning counselor and contains suggestions regarding training, record keeping and supervision. The first five copies of this 64-page booklet, available in English, Spanish and French, are free. Additional copies are US $3.25 each.

Also available is *Family Planning Counseling and Voluntary Sterilization: A Reference Guide for Counselors*, a pocket-sized card to carry or leave on a desktop as a handy reminder about the key points in counseling. The card, available in English, French and Arabic, highlights information that counselors should discuss with clients to help them make informed decisions about their use of contraception. The first five copies are free; additional cards are US $1.25.

To obtain either of these materials, contact: AVSC, 79 Madison Avenue, New York, NY 10016 USA, or call: 212-561-8000.

New FHI Publications

To request any of the following publications, write to: Publications Assistant, Family Health International, P.O. Box 13950, Research Triangle Park, North Carolina, USA 27709. Please request publications by number.

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