

# Network

FAMILY HEALTH INTERNATIONAL, VOL. 15 NO. 2, DECEMBER 1994

## Contraceptive Choices



# News Briefs

## NETWORK WINS

### GLOBAL MEDIA AWARD

Family Health International's quarterly health bulletin, *Network*, has been named Best Population Journal in the 1994 Global Media Awards for Excellence in Population Reporting. The awards are sponsored by the Washington-based Population Institute.

Egyptian Prime Minister Dr. Atef Sedky presented the award prior to the opening of the International Conference on Population and Development held in Cairo Sept. 5-13. During the year, *Network's* theme issues examined such topics as the role of family planning among teenagers, women and AIDS, ways to improve the quality of family planning services and the benefits of family planning on maternal health. Nash Herndon, FHI managing editor, accepted the award in Cairo on behalf of the staff. *Network* is published in English, French and Spanish four times a year and once a year in Russian.

Other 1994 Global Media Award winners were: *The Washington Post*, best major daily; *Expreso*, Lima, Peru, best editorial support; *Time* magazine, best periodical; *Kenya Times*, Stephen Mureithi, best individual reporting; *The Washington Post*, Judy Mann, best columnist; Radio-Bridge Overseas Trust, Zimbabwe, best radio program; Inter Press Service, Rome, most conscientious news service; *Post-Intelligencer*, Seattle, WA, USA, best cartoonist; *Earth Times*, best population/environmental reporting effort; *Newsweek International*, best team effort for "Asia's Choking Cities;" Turner Broadcasting,

for two documentaries, "People Count" and "Small Islands...Big Issues;" the Egyptian State Information Service, best combined media effort; and RPM/RADAR Advertising Agency, Turkey, best commercial advertising for launching "OKEY," a condom brand.

### BREAST CANCER

#### LINK UNRESOLVED

A widely-publicized U.S. study has found a statistically significant association between a woman's having had an induced abortion and her risk of breast cancer. FHI researchers say, however, that findings from this and numerous other studies are inconsistent and more research is needed.

"The causal question has not been settled," says Dr. Willard Cates, FHI medical director. "Many other studies have examined the relationship between induced abortion and breast cancer — some found increased risks, others reported decreased risks and still others found no association."

FHI epidemiologists are involved in assessing the data and keeping track of the evolving scientific consensus.

In the new study of 1,800 U.S. women, those who were 45 years of age or younger and who had an induced abortion were found to have a 50 percent greater risk of developing breast cancer than women of comparable age who had been pregnant at least once but had never had an abortion.

The study, however, had design limitations that may have affected its findings. For example, Dr. Cates notes that women with breast cancer may be more likely to report a previous abortion than would healthy women. Epidemiologists refer to this as "recall bias." If a study were not carefully controlled for this problem, its findings may not be true, he says.

Because of the way the study was designed, even the study's authors said that their findings should be viewed with caution. The study was conducted by a team headed by Dr. Janet R. Daling of the Fred Hutchinson Cancer Center in Seattle, WA, USA and appears in the November 2 issue of *The Journal of the National Cancer Institute*.

### HIV PREVENTION

#### CONFERENCE

Family Health International's AIDSCAP Project is soliciting abstracts for presentations to be given at the Third USAID HIV/AIDS Prevention Conference August 7-9, 1995, in Washington. The conference will highlight USAID-funded HIV prevention projects and examine future directions for prevention activities, including AIDS care and support.

Representatives from HIV prevention projects that receive USAID financial support are invited to submit abstracts for consideration. The deadline for submission is February 1, 1995.

Conference participants must register by April 15, 1995. There is no registration fee. To obtain a copy of the abstract guidelines or for more information about the conference, contact the conference organizer at FHI/AIDSCAP, 2101 Wilson Boulevard, Suite 700, Mail Stop 731, Arlington, VA 22201, USA, or telephone (703) 516-9779, or fax (703) 516-4489.

### PILL SWITCHING

#### NOT NECESSARY

#### DURING BREASTFEEDING

A recent FHI survey of international experts found agreement that breastfeeding women who use progestin-only pills (POPs) do not need to switch to combined oral contraceptives (COCs) during breastfeeding.

Some health-care providers may have the misunderstanding that such a switch is preferable, since combined pills may be used safely six months after giving birth and the pill-taking regimen is not as strict for COCs as it is for progestin-only pills.

"POPs can be used safely and effectively throughout the period of lactation and there is no need to switch to another contraceptive method or another type of pill," says Cynthia Visness, the FHI researcher who conducted the survey.

Sixteen experts contributed to and endorsed a statement that says breastfeeding women who wish to use oral contraceptives should use POPs, while COCs should be avoided during the first six months. POPs are preferable for breastfeeding women because they do not lower breastmilk volume while COCs do. Also, POPs do not expose breastfed infants to estrogen, which is present in COCs. After six months most infants do not rely solely on a diet of breastmilk, so the problems associated with COCs and breastfeeding have less impact on the infant.

Endorsing the statement were experts from the Margaret Pyke Centre, International Planned Parenthood Federation, the Institute for Reproductive Health at Georgetown University, and the Program for International Training in Health. A copy of the statement can be obtained by writing Cynthia Visness, Senior Research Analyst, Family Health International, P.O. Box 13950, Research Triangle Park, NC 27709, USA.

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*Having appropriate contraceptive choices available encourages family planning and promotes healthy families. This family of four lives in the village of Mal Paso in Bolivia, near Cochabamba.*  
Sean Sprague/Impact Visuals



# Contraception After Unprotected Sex

Many women worldwide do not know contraception following intercourse is feasible, or that it is available.

Couples interested in contraception ideally prepare in advance to use it, visit their health-care provider or another outlet to obtain it, and use it consistently without incident. But occasionally, human nature, contraceptive mishaps and other difficulties can result in unprotected intercourse, placing women at risk of unwanted pregnancy.

Women who experience unprotected sex for whatever reason, including sexual assault, are among those who can protect themselves from pregnancy after intercourse by using "emergency contraception." "A very good indication for use of emergency contraception is as a backup method, when methods are used incorrectly or fail for other reasons," says Dr. Roberto Rivera, FHI's corporate director for international medical affairs. "They can be used when a condom breaks, a woman's diaphragm gets dislodged, or a planned method is not used."

Among available contraceptive methods, oral contraceptives and intrauterine devices (IUDs) can work safely and effectively as emergency contraception if they are used in a specific manner. For example, when used as emergency contraceptives, oral contraceptives are usually taken in higher doses than for regular use.

Emergency contraception, also sometimes called postcoital contraception, is not as effective as consistent use of contraception

and can cause unpleasant side effects. Therefore, contraception after coitus should not be used repeatedly.

"Most women should use emergency contraception only in a true emergency as a backup and not as a regular contraceptive method," says Dr. Linda Potter, an FHI public health scientist who studies oral contraceptives. "But if a woman is at risk of pregnancy because she was not protected at a particular time, she needs to know she can use emergency contraception."

Combined oral contraceptives (the pill) are most often recommended for emergency contraception because they are effective, well-studied and readily available. Other hormonal approaches involve the use of progestin-only pills; estrogen; danazol, a synthetic androgen; and mifepristone (RU 486), an antiprogestin.

Timing is a critical factor in effective use of emergency contraception, which prevents pregnancy by blocking ovulation, fertilization, transport of the fertilized ovum (egg), or implantation.<sup>1</sup> IUDs generally must be inserted within five days. Hormonal methods are most effective if administered within the first 24 hours following unprotected intercourse and most hormonal approaches must be initiated within 72 hours (three days). Some hormonal methods must be used earlier. Progestin-only pills should be administered within eight hours of intercourse while estrogen should be given within 48 hours.

## LACK OF KNOWLEDGE

Many women worldwide do not know that emergency contraception exists and is readily available. Some providers do not offer information about it because they worry that it causes health risks, that women will use it in place of regular, more effective contraception or because they believe the methods act as abortifacients.

However, emergency contraception is generally safe and can be quite effective if used properly. "Most people agree that pregnancy begins six days after fertilization, when implantation occurs," says Dr. Rivera. "Methods used as emergency contraception are, by definition, methods used before implantation. Methods used after implantation actually cause early pregnancy terminations. One should remember that existing pregnancy is a contraindication for any contraceptive method."

Many family planning providers lack adequate knowledge of emergency contraceptive methods and practices, according to a recent FHI survey funded by Population Action International.<sup>2</sup> Some family planning providers offer no emergency contraception, says Marilyn Metcalf-Whittaker, associate director of the Clinical Applications Division at FHI, and a researcher on the study.

Among those who do, "there is a broad range of methods being offered, including different regimens and requirements for clients," she says. Providers need to know "that there are regimens that are commonly used and seem to be the most effective."

Many women are discouraged from using emergency contraception because they cannot get into a clinic soon enough. Women need information about and access to emergency contraception, experts say, particularly unmarried women and adolescents, who are among the primary potential users of emergency contraception.

Once a woman has requested emergency contraception, counseling should be provided and should cover available methods, including their effectiveness, contraindications and side effects. A provider also must address what the client will do if she becomes pregnant. When a woman requests emergency contraception, providers can use the opportunity to counsel her on more effective, regular contraception.

## THE PILL

At the Clínica Semain in Monclova, Mexico, Dr. Daniel Moreno and his colleagues receive requests for emergency contraception from several clients each month. Most are unmarried women under the age of 25.

"They may call on the telephone and say 'I have had unprotected sex and I do not want a baby. What can I do?,'" Dr. Moreno says. He recommends that clients who need emergency contraception use combined oral contraceptives as long as they have no contraindications for pill use.

In Mexico, oral contraceptives can be bought at pharmacies. Worldwide, however, there is disagreement among experts about whether a woman should be able to obtain emergency contraception without a doctor's prescription or direction.

As emergency contraceptives, oral contraceptives offer "the best balance between high efficacy and minimal side effects, and have the most available data," says Dr. Anna Glasier, an expert in emergency contraception and director of family planning and well-woman services at the Dean Terrace Centre in Edinburgh, Scotland.

When used for emergency contraception, combined oral contraceptives are often known as "morning after" pills, although this name is misleading. A woman must take the first dose of oral contraceptives as soon as possible, as long as it is within 72 hours of an act of unprotected intercourse. A second dose must be taken about 12 hours after the first.

During emergency use, combined oral contraceptives prevent about 75 percent of the pregnancies otherwise expected, according to some experts.<sup>3</sup> Mifepristone (RU 486), an anti-progestin that blocks hormones necessary for implantation, may be even more effective

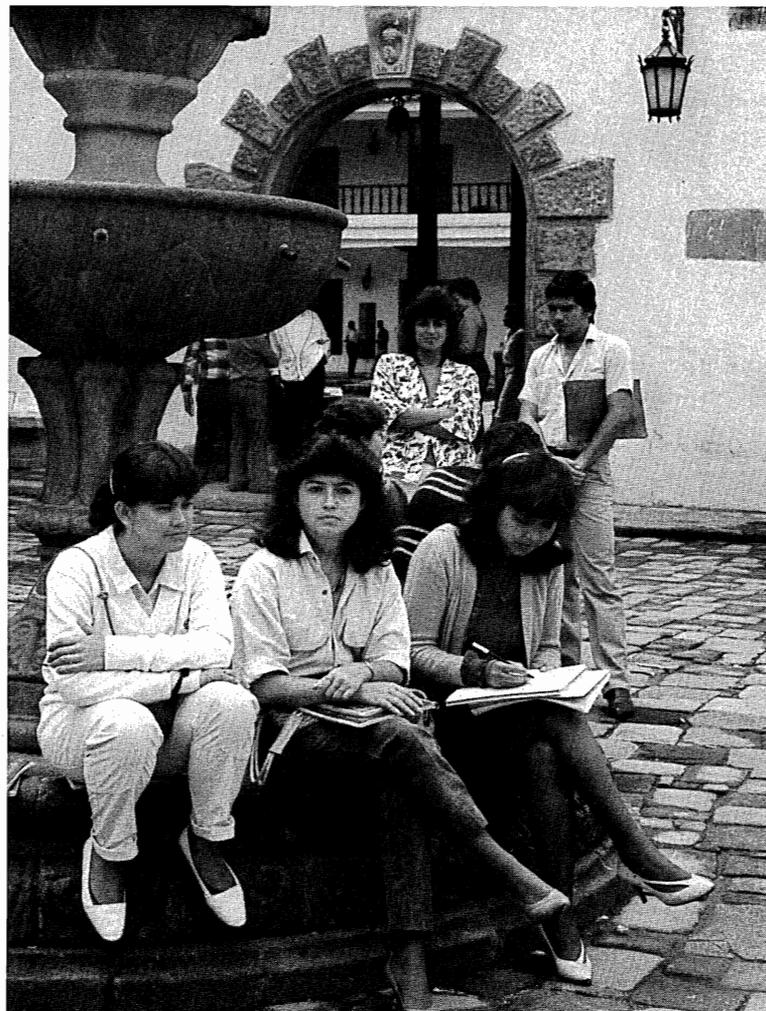
in preventing pregnancy than combined oral contraceptives when used as emergency contraception.

When used for emergency contraception, oral contraceptives are taken in higher doses than during regular use. In what is called the Yuzpe regimen, a dose consists of 100 mcg of ethinyl estradiol plus 1.0 mg of norgestrel, or 100 mcg of ethinyl estradiol plus 0.5 mg levonorgestrel. Doses are given 12 hours apart.<sup>4</sup> Because higher dosages are needed than are found in a single contraceptive pill, multiple pills are taken per dose — two pills of the brand Ovral, for example, or four of the brand Nordette.

Oral contraceptives change a woman's hormonal levels, and experts believe this prevents pregnancy during emergency use by either disrupting ovulation, egg transport, uterine lining development or possibly fertilization.

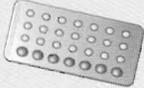
"There is not a single mode of action," says Dr. Paul Van Look, associate director of the World Health Organization's Special Programme of Research, Development and Research Training in Human Reproduction. "It depends on the time of the [menstrual] cycle and on other factors, including the sensitivity of the individual to the hormones given."

CARLOS CONDE/IDB



STUDENTS AT THE UNIVERSITY OF CAUCA, COLOMBIA, VISIT BETWEEN CLASSES. WORLDWIDE, MANY YOUNG WOMEN ARE NOT AWARE THAT THEY CAN PREVENT PREGNANCY AFTER UNPROTECTED SEX BY USING EMERGENCY CONTRACEPTION.

## EMERGENCY CONTRACEPTIVE METHODS

Method		Timing After Coitus	Dosage*
Combined oral contraceptives		Within 72 hours	100 mcg ethinyl estradiol and 0.5 mg levonorgestrel first dose; repeat dose 12 hours later
Progestin-only oral contraceptives		Within eight hours	0.75 mg levonorgestrel first dose; repeat dose 12 hours later
Estrogen		Within 48 hours	5 mg ethinyl estradiol first dose; repeat dose each day for four days (five days total)
Androgen		Within 72 hours	400 to 600 mg danazol first dose; repeat dose 12 hours later
Antiprogestin		Within 72 hours	600 mg mifepristone (RU 486), single dose
IUD		Insertion within five days	

Emergency contraception (postcoital contraception) is used after unprotected coitus to avoid pregnancy by preventing ovulation, fertilization or implantation of the fertilized ovum (egg) in the uterus.

\* Number of pills per dose varies from brand to brand, depending on the pill's strength.

While no long-term complications have been reported for emergency use of oral contraceptives,<sup>5</sup> more than half of users suffer short-term side effects, mostly nausea and vomiting.<sup>6</sup> Taking the pills with food or taking anti-nausea medicine may help to avoid these problems. Some health-care providers recommend that if a client vomits within one to three hours of taking a dose, she should repeat the dose.

Emergency contraception is generally safe for women. But some providers worry that hormonal contraception, if used after intercourse, could harm development of a fetus if the method failed. However, no birth defects have been reported in infants born to mothers who used combined oral contraceptives for emergency contraception.<sup>7</sup>

Hormones used after intercourse prevent uterine pregnancy, but they appear less effective in preventing ectopic pregnancy, which has been reported during use of some methods. This type of pregnancy usually

occurs in the fallopian tube, outside of the uterus, and can pose a severe health risk to women.

"It is not that emergency contraception increases the risk of ectopic pregnancy," Dr. Van Look says. "Emergency contraception simply is more effective in preventing uterine pregnancy than pregnancy outside the uterus."

### OTHER HORMONAL METHODS

Progestin-only pills may be an emergency contraceptive option for women who cannot use estrogen and have no contraindications to progestin, with the first dose of 0.75 mg of the progestin levonorgestrel given within eight hours of coitus and a follow-up dose 12 hours later.

However, giving the first dose even later — within 48 hours, with a second dose 12 hours later — was about as effective as the Yuzpe regimen for combined oral contraceptives, according to a 1993 study of more

than 800 women conducted by the Family Planning Association of Hong Kong. Women experienced side effects from progestin-only pills, but less frequently than those who took combined oral contraceptives. For example, nausea was reported after treatment by only 16 percent of those using progestin-only pills, compared to 47 percent of women who used combined pills.<sup>8</sup>

While emergency contraception typically refers to a way of dealing with an unplanned exposure to pregnancy, a similar approach is used as a planned method for women who have very infrequent intercourse. Progestin-only "visiting pills," for example, are available in China as a planned postcoital contraceptive for couples who live and work in different areas and, consequently, have infrequent sexual contact.

Progestin-only pills are marketed in Thailand, Hungary and other countries for use after intercourse — some under the brand name Postinor (one tablet for the initial dose within eight hours of intercourse and one tablet 24 hours later; if a woman has intercourse on subsequent days she repeats the dose every 24 hours, for a maximum of seven doses). Many progestin-only pills, however, have low doses of levonorgestrel. More pills must be taken of those brands — 20 tablets for each dose of the brand Ovrette, for example.

Other methods that have been tested as emergency contraception include danazol, an androgen hormone used to treat endometriosis, and high-dose estrogen.

High-dose estrogen was the first method used widely for emergency contraception. It is very effective and is still used in

some countries, but it causes severe nausea in many women. In addition, one form of estrogen — diethylstilbestrol (DES) — was found to cause birth defects in children whose mothers used it to prevent miscarriage and an increased risk of vaginal cancer in the mothers themselves.

Studies on danazol as an emergency contraceptive have had mixed results. At least one study showed it to be about as effective as the Yuzpe regimen, while another was halted because its effectiveness was considered unacceptably low.<sup>9</sup>

## IUDs

If a woman needs emergency contraception more than 72 hours after unprotected intercourse, an IUD is the best option, as long as a woman does not have any contraindications for IUD use. Insertion should be done within five days of unprotected intercourse, according to the World Health Organization. The method works well for women who have not come to a clinic soon enough for hormonal regimens.

IUDs, particularly copper ones,<sup>10</sup> are very effective as emergency contraception. A review of nine studies found that only one of 879 women using copper IUDs for emergency contraception became pregnant.<sup>11</sup> When used for emergency contraception, IUDs are thought to prevent pregnancy by causing inflammation in the uterine lining, thus preventing implantation.

IUD side effects and contraindications are the same during regular and emergency use, and insertion follows the same procedure for both purposes. IUDs are an excel-

lent option for women in a mutually monogamous relationship who want to continue using the method. But some clients who need emergency contraception are the ones least suited for IUD use — women at risk of sexually transmitted diseases (STDs) because they, or their partners, have multiple sexual partners. STDs can lead to pelvic inflammatory disease which, if untreated, can cause infertility.

“These are really young women who have had unprotected intercourse sometimes forced on them and sometimes with partners they do not know well,” says Dr. Joseph Ruminjo, an obstetrician-gynecologist at Kenyatta National Hospital in Nairobi, Kenya. “It makes you worry about the potential for STDs.” Women at risk of STDs should be advised not to use IUDs for any reason, including emergency contraception.

## DIFFERENT REGIMENS

Worldwide, one of the biggest barriers to the use of emergency contraception is that many providers are not aware of its availability and effectiveness.

In 1993 and 1994, FHI surveyed 1,586 health-care professionals in 15 countries on emergency contraceptive practices. Among the 209 respondents, emergency contraception is not practiced widely. The health-care professionals who offer emergency contraception prescribe vastly different doses or regimens of a variety of treatments.

Almost 70 percent of the respondents to the survey who offer emergency contraception provide combined oral contraceptives,

while 42 percent offer estrogen and 39 percent insert IUDs. Some providers offer more than one method.

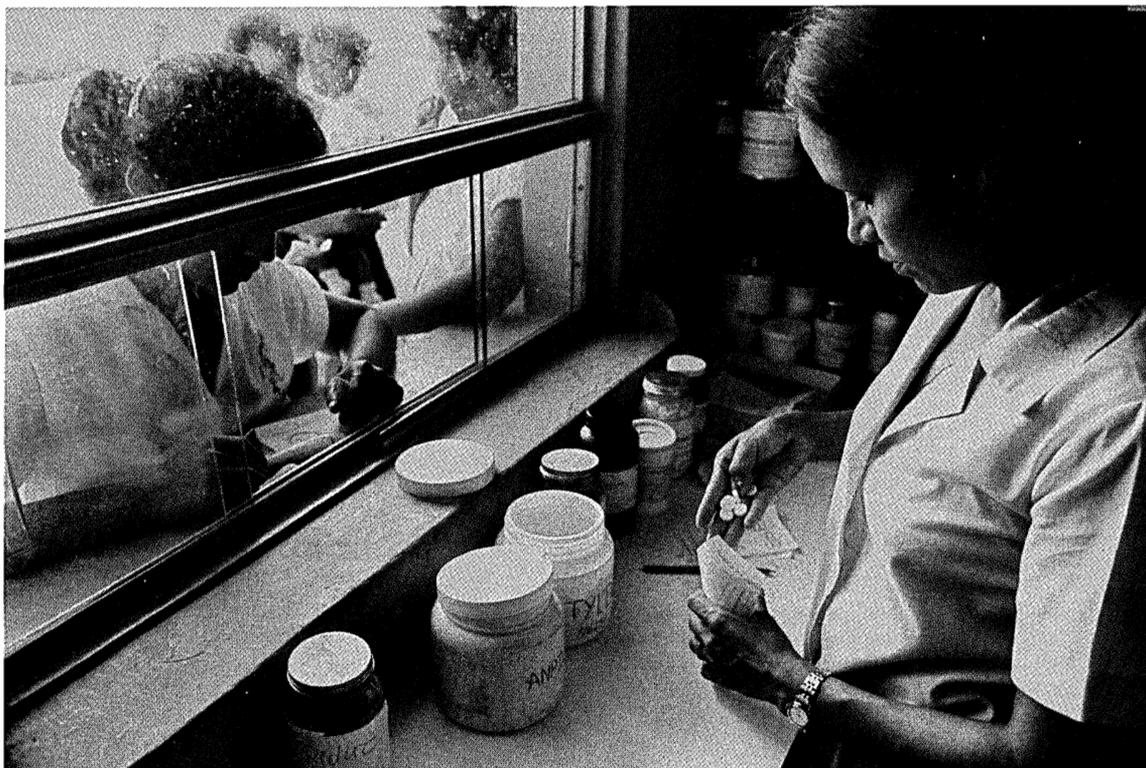
“Part of the difference is due to a difference in what providers know about and what they have available for contraception overall,” says Dr. Cindy Waszak, an FHI social scientist, who worked on the study. Other studies worldwide also have found that providers’ knowledge of emergency contraception is limited.<sup>12</sup>

Providers who do not offer emergency contraception to their clients often cite a lack of resources, information, requests or institutional support for their decisions. Many respondents to the FHI study expressed interest in learning more about emergency contraceptive practices.

Even if providers are well-versed in emergency contraceptive methods, other difficulties may prevent women from getting them. In the United States, for example, oral contraceptives are not labeled for use as emergency contraception, which may keep many providers from prescribing them.

Worldwide, many women do not know such methods are available, or do not know that timing is extremely important in obtaining emergency contraception. In a study in inner-city London, less than one-fifth of women knew the 72-hour time limit for using oral contraceptives as emergency contraception.<sup>13</sup>

MARVIN COLLINS/IMPACT VISUALS



### PRESCRIPTIONS FOR ORAL

CONTRACEPTIVES ARE HARD TO GET AT

NIGHT OR ON WEEKENDS, MAKING USE OF

THE PILL SOON AFTER UNPROTECTED

INTERCOURSE DIFFICULT FOR MANY

WOMEN. AT THIS CLINIC IN CONDEGA,

NICARAGUA, A PHARMACIST DISPENSES

DRUGS.

## MIFEPRISTONE (RU 486): FEWER SIDE EFFECTS, ONE DOSE

Mifepristone (RU 486), widely known as an abortion pill, may be useful as an emergency contraceptive. It is effective, has fewer side effects than combined oral contraceptives and can be given in one dose instead of the two required for combined oral contraceptives — potentially increasing the likelihood of correct use.

Mifepristone blocks the action of progesterone, a hormone necessary for implantation to take place and to maintain pregnancy. When mifepristone is used in combination with a prostaglandin in early pregnancy, it acts as an abortifacient. When used as emergency contraception, mifepristone appears to prevent implantation,<sup>1</sup> and it may affect ovulation, experts say.

In a study of women using emergency contraception within 72 hours of unprotected intercourse, none of 402 who took mifepristone became pregnant, and they experienced less nausea, vomiting and fewer other side effects than those using combined oral contraceptives. Four of 398 women who used combined oral contraceptives in the standard Yuzpe regimen became pregnant, a difference that was not statistically significant.<sup>2</sup>

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Although emergency contraception is available at Kenyatta National Hospital in Nairobi, Dr. Ruminjo has seen women risk their health because they do not know about it or try to use their own versions. "Women might take any type of tablets," Dr. Ruminjo says. "The most commonly used are aspirin or chloroquine. Another woman swallowed detergent powder because she thought it would prevent a pregnancy after unprotected intercourse. She died."

Clinic schedules and requirements for prescriptions keep some clients from getting emergency contraception in time. "Pharmacies are often closed at night and general practitioners are closed on weekends and at night," says Dr. O.A. Ladipo, director of South-to-South Cooperation in Reproductive Health in Brazil. "Weekends are often

A second study of 616 women using emergency contraception within 72 hours had similar results. None of the women using mifepristone became pregnant, and fewer experienced side effects than with the Yuzpe regimen.<sup>3</sup>

While effective, mifepristone was more likely to delay menstruation than the Yuzpe method in both studies. Hence, mifepristone can cause anxiety for a woman concerned about being pregnant.

A World Health Organization study is examining whether the mifepristone dose can be lowered without reducing its effectiveness, from the 600 mg used in the study to as little as 10 mg. Initial results may be available as soon as mid-1995.

Developed in 1988 in France, the drug is approved for use as an abortifacient in France, England, China and Sweden. Clinical trials have been conducted in 20 countries, including India, Cuba, Singapore and Zambia.<sup>4</sup>

—Carol Lynn Blaney

when sexual intercourse takes place, especially for those at risk. So clients have that barrier — they cannot get to a physician to have them prescribe the methods.

"Providers themselves may discourage clients from having access to emergency contraceptive pills, because they would rather they use modern contraceptive methods in a planned way," Dr. Ladipo says. "Providers need to be educated about the merits of this approach and the need for this approach among particular clients. All women at high risk of pregnancy should know about emergency contraception."

—Carol Lynn Blaney

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# Uniform Guidelines Improve Client Care

Replacing “good guesses” with guidelines helps assure high-quality service from one clinic to the next.

**I**s a woman ever too young or too old to take the pill? What types of contraceptives are best for breastfeeding women? Should women who have never been pregnant use the IUD?

Clients asking these questions may receive different information from health-care providers — even from providers in the same village or clinics in the same city.

Uniform national guidelines on the delivery of family planning methods and services can improve client care. Guidelines, based on up-to-date scientific information, provide instruction for the safe and efficient delivery of family planning services. Guidelines also define minimum standards of care for providers.

“Clients have a right to high-quality care, and service providers have needs that must be met to deliver that quality,” says Dr. Carlos Huezo of the International Planned

Parenthood Federation (IPPF) in London.

“The needs of service providers include the need for information, training, and supplies, but providers also need guidance on the job.”

Service delivery guidelines can help ensure consistency among family planning programs in different settings. While clinics may not offer the same services, due to limits on financial or human resources, guidelines can direct them to offer the same standards of care.

“Guidelines imply that all doctors will give the same standard of care for the same service, that all community-based workers will give the same standard of service,” says Dr. Karen Hardee, FHI senior research associate. “It should mean that such things as eligibility criteria, contraindications and follow-up schedules are the same at different service delivery points.”

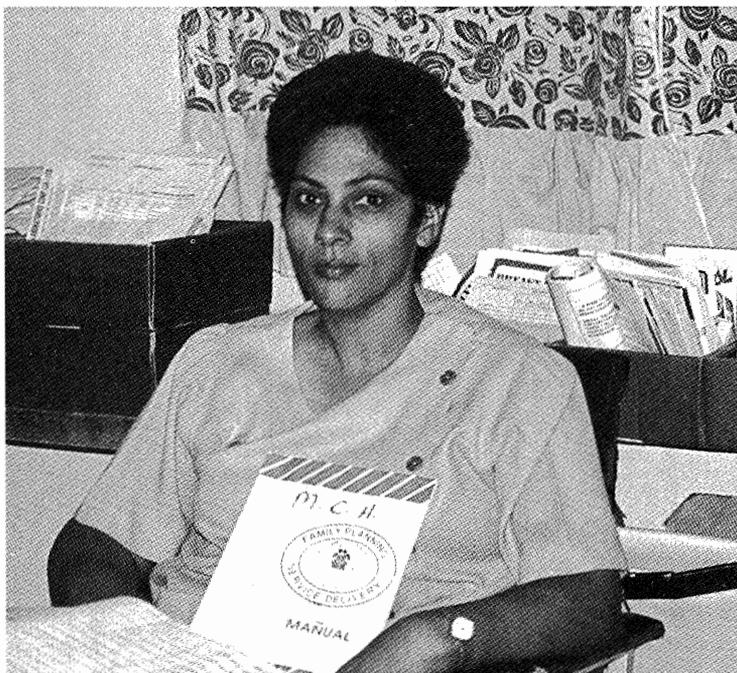
The consistency of the information provided to health-care workers is an important factor influencing quality of care, says FHI’s *Catalogue of Family Planning Service Delivery Guidelines*. Without consistency, confusion may result, thereby reducing quality care.

“Service policies, standards and procedures guidelines shape and give direction to service delivery programs,” says Lynn Knauff of the U.S.-based Program for International Training in Health (INTRAH). “From the perspectives of the service providers, trainers and supervisors, guidelines replace ‘good guesses’ with clear expectations and comprehensive guidance.”

## ADAPTING TO LOCAL NEEDS

At the international level, several health organizations have written guides for family planning service delivery, which typically

WRITTEN MATERIALS AND TRAINING HELP INFORM PROVIDERS ABOUT NATIONAL GUIDELINES. A NURSE AT NORMAN GARDENS HEALTH CENTER IN KINGSTON, JAMAICA HOLDS FAMILY PLANNING GUIDELINES.



KAREN HARDEE/FHI

include eligibility criteria for various methods, recommendations on how providers can address client concerns, management of potential side effects, and follow-up schedules for clients. Guidelines can be complementary, offering information on different aspects of service delivery.

These documents can be used as references for countries developing national family planning guidelines and policies, says Dr. Roberto Rivera, FHI's corporate director of international medical affairs.

"International guidelines are sources of updated, scientifically correct information," says Dr. Rivera, who has helped health experts in Mexico, Costa Rica and Nicaragua develop national guidelines and policies. "They should be adapted according to local needs."

While international documents focus on medical eligibility criteria and counseling techniques, national guidelines on contraceptive methods and services take into account cultural norms and economic resources.

"It's very important to recognize those elements in developing national guidelines," says Dr. Rivera. "You may say that IUDs can be used by adolescents, but the social perception will certainly play a role in whether they are included in the national standards. Besides social needs, countries must consider program resources. A service may be important, but do you have the resources and the means to develop that service?"

Anne Wilson, a clinical specialist who works in the U.S. Agency for International Development (USAID) family planning division, agrees. "Ideally, the international

guidelines should be more conceptual — they should give the broad framework. The purpose of national guidelines would be to look at that broad framework and apply it to the particular needs of a country."

After national guidelines are developed, a crucial final step remains. Physicians, nurses and other health providers throughout a country must be adequately informed about the guidelines in order to use them. Training, workshops, dissemination of written materials and similar activities are necessary to help achieve consistent adherence to national guidelines by all providers.

#### INTERNATIONAL GUIDELINES

One international guide, prepared by the World Health Organization (WHO), offers updated medical criteria for the initiation of combined oral contraceptives, progestin-only pills, Norplant, the copper intrauterine device, and the injectable contraceptive, DMPA (depot-medroxyprogesterone acetate).<sup>1</sup> The guide is the first in a series of WHO reports that also will address initiation of other contraceptive methods, including barrier methods, natural family planning, and emergency contraception, as well as continuation of methods.

"Each individual method has certain managerial requirements," says Dr. Mark Belsey, program manager for WHO's Division of Family Health. "For instance, natural family planning has very different requirements for provider training than IUD insertions or sterilizations."

The new guide, he says, is an attempt to make available a wide range of contraceptive choices. "The purpose is to provide the

technical background information for countries trying to adopt a broader approach to contraceptive availability," says Dr. Belsey. "Programs need to respect the whole concept of contraceptive choice. The wider the choice, the more successful the program is likely to be" in meeting client needs.

The WHO guide uses an approach that helps providers determine client eligibility for use of a particular method. Based on results of animal and human studies, WHO experts have weighed the risks and benefits of the methods and developed four categories of eligibility:

- Category 1, in which there are no restrictions for contraceptive use.
- Category 2, in which the advantages of using the method generally outweigh the risks.
- Category 3, in which the theoretical or proven risks usually outweigh the advantages of the method. Consequently, the method should not be used unless other appropriate methods are not available.
- Category 4, in which the health risks of using the method are unacceptable.

The categories are applied to more than 40 health conditions, in an effort to help providers screen appropriate and inappropriate clients. For example, for a woman who is pregnant, all contraceptive methods are "Category 4" (unacceptable health risks). For a client at risk of acquiring HIV, using an IUD would be Category 3 (risks outweigh advantages).

WHO developed the guide with input from family planning program managers, technical experts, scientists, women's health groups and research organizations, including FHI. WHO also has published service delivery guidelines and books on the management of specific contraceptives, such as Norplant and injectables.

Another set of service procedure guidelines has been developed by the Technical Guidance Working Group, a USAID group that includes representatives from FHI, INTRAH, the Population Council, Pathfinder Fund, IPPF, AVSC International and other health organizations. The working group addressed two problems: that existing family planning procedural guidelines are sometimes inconsistent; and that, in too many instances, existing guidelines discourage access to services by not taking into account current scientific evidence.<sup>2</sup>

The recommendations developed by the working group focus on hormonal methods and IUDs. Through a series of questions and answers, guidelines explain the scientific rationale for procedures for initiation and continuation of each method.

## HOW TO OBTAIN GUIDELINES

The Technical Guidance Working Group's document, *Recommendations for Updating Selected Practices in Contraceptive Use, Volume I*, can be obtained by writing Ms. Sarah Davis, Office of Population/Research Division, Bureau for Research and Development, USAID, Washington, DC 20523-1819 USA. Orders may be faxed to Ms. Davis at (703) 841-0327. One copy per request is available for medical directors and other clinicians involved in policy-making. The cost has yet to be determined.

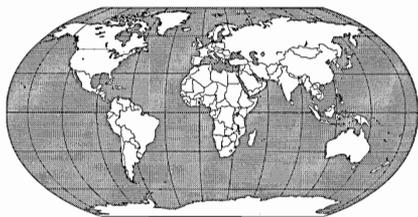
INTRAH has published several guides, including *INTRAH Guidelines for Clinical Procedures in Family Planning* (U.S. \$25); *Assessing Service Access: A Checklist for Family Planning Trainers, Preceptors, Supervisors and Managers* (U.S. \$4); and *Removing Medical Barriers to Family Planning Services* (U.S. \$4). For copies write to INTRAH, 208 N. Columbia Street, CB# 8100, Chapel Hill, NC 27514 USA. The fax number is (919) 966-6816.

*IPPF Medical and Service Delivery Guidelines* are published in two formats, as a book and as ringbinder notebooks. Guidelines in book form cost U.S. \$16, and ringbinder notebooks are U.S. \$36. Copies are available free of charge to individuals and organizations who have difficulty paying. To obtain a copy, write IPPF Distribution Unit, Regent's College, Inner Circle, Regent's Park, London NW1 4NS, U.K.

AVSC International has published guides on contraceptive methods, including *Mimilaparotomy Curriculum for Physicians and Nurses* and *No-scalpel Vasectomy: an Illustrated Guide for Surgeons*. For copies, contact Bob Goldberg, Public Information Coordinator, 79 Madison Ave., New York, NY 10016 USA.

# FAMILY PLANNING GUIDELINES

## International Guidelines



provide current, scientific information

## National Policies



shape international guidelines to reflect cultural norms and available resources

## Clinical Procedures



procedures and policies reach providers throughout a country, using written materials, workshops or similar means

Guidelines for health providers should be based upon a national health policy, which in turn has been shaped by current scientific findings reflected in international

guidelines. Guidelines can help providers organize, manage, deliver and monitor quality services in ways that are consistent with national goals and objectives.

Some of the questions addressed are: When can postpartum women start using combined oral contraceptives? Does a client need to see a doctor to receive combined oral contraceptives or an IUD? Should progestin-only injectable contraceptives be discontinued because of prolonged amenorrhea? What should the routine follow-up schedule be for clients using Norplant? Is there a maximum or minimum age limit for women using hormonal contraceptives or IUDs?

The guidelines also offer recommendations on medical procedures that are necessary or unnecessary for safe administration of hormonal contraceptives and IUDs:

- Class A procedures are those "essential and mandatory in all circumstances."
- Class B include procedures that are scientifically justified but not appropriate for all clients in all settings.
- Class C are for procedures that may be appropriate for maintaining good health but are not directly related to the safe use of a contraceptive method.
- Class D are procedures that are unnecessary and irrelevant to safe contraceptive use.

For example, a pelvic examination is a Class A (essential) procedure for IUD use but a Class C (appropriate but not necessary) procedure for use of hormonal methods, such as oral contraceptives. In either case, however, a pelvic examination helps maintain good health.

IPPF issued comprehensive service delivery guidelines in 1992. Targeted to providers, program managers, supervisors and trainers, the guidelines included chapters on the technical aspects of contraceptive provi-

sion, including information on hormonal contraceptives, IUDs and surgical sterilization, and also the "human" aspects of service delivery — counseling and clients' rights.

"The whole document is focused from the point of quality of care," said Dr. Huezo of IPPF, one of the authors. "The guidelines are one of the instruments to achieve quality. We want to improve quality because it is a right of individuals."

In the two years since the guidelines were published, IPPF has introduced them to providers through a series of national and regional workshops on quality of care in southeast Asia and Africa, including the Arab region. Guidelines also have been distributed in eastern Europe. The guidelines, which were written in English, have been translated into French, Arabic, Russian, Albanian, Bulgarian and Rumanian, and they are now being translated into Spanish and Bengali.

IPPF is in the process of revising its guidelines. New chapters are being written on infection prevention, sexually transmitted diseases and emergency, postcoital contraception, and original chapters are being updated to incorporate new scientific information, as well as comments from field test participants and providers who have used the guidelines. In addition, IPPF hopes to publish a second volume that will include recommendations for managers of family planning services, such as recordkeeping, planning and organizing clinics and community-based services, and the logistics of supply.

## NATIONAL POLICIES

Examples of countries that have recently developed or are working to draft their own national guidelines include Mexico, Nepal, Ghana and Cameroon.

Mexico, with assistance from FHI, recently updated its 1986 family planning guidelines, part of a larger effort to develop norms for the country's broader range of health-care services. The process took approximately nine months and involved representatives of both public and private health organizations, including the Ministry of Health, local universities, the scientific community and health care institutions, as well as women's groups.

"The norms incorporate all contemporary and available technology on contraception," says Dr. Gregorio Pérez-Palacios, who chaired the committee that wrote the national guidelines for family planning and maternal and child health. "We have incorporated guidelines for vasectomy, Norplant, and the monthly injectable Cyclofem. We also have incorporated information about counseling requirements for the methods, and we have eliminated a number of medical barriers to contraceptive use."

One of the most significant changes in Mexico's new family planning guidelines is the elimination of obstacles for young people seeking contraception.

"In the previous norms, there were a lot of barriers for the prescription of contraceptives to adolescents," says Dr. Pérez-Palacios. "Now all these limitations have been eliminated ... and an adolescent is eligible to receive practically all contraceptive methods."



SEAN SPRAGUE/IMPACT VISUALS

A MOTHER IN NEPAL LEARNS ABOUT ORAL CONTRACEPTIVES AT A FAMILY PLANNING CENTER IN KATHMANDU. GUIDELINES HELP ASSURE THAT THE SAME HIGH STANDARDS ARE FOLLOWED AT ALL CLINICS.

Guidelines also revised out-of-date information on service delivery. For example, the 1986 guidelines said nulliparous women could not receive injectable contraceptives. There is no scientific reason to exclude nulliparous women, so that restriction has been eliminated.

Mexico's guidelines, for the first time, will standardize service delivery in both the public and private sectors. Guidelines also were written with a projection of the costs and benefits of each individual recommendation.

The next step, Dr. Pérez-Palacios says, is to educate providers about new guidelines—a complex and challenging task. New standards will mean changes in training programs, courses, and publications for providers, and guidelines must be distributed in remote rural areas as well as cities.

In the Asian country of Nepal, where approximately one-fourth of the couples of reproductive age use family planning, policy-makers, trainers and providers are working to update national service delivery guidelines.

Efforts began in 1991 when a task force was appointed by the Ministry of Health to develop a quality assurance system for family planning. One of the task force's main objectives was to review existing family planning

practices and to develop national standards for service delivery. Guidelines were written, and this year new chapters will be added, including chapters on infection prevention, reproductive tract infections, sexually transmitted diseases, and infertility.

In conjunction with the effort to standardize guidelines, international organizations are working with national groups to develop a curriculum for contraceptive service delivery and a manual for nurses, paramedics and trainers. Additionally, guidelines for distribution of DMPA through pharmacies have been developed, and workshops to educate trainers have been held. FHI, AVSC International, the Johns Hopkins Program for International Education in Reproductive Health (JHPIEGO), John Snow Inc., and the Nepal Fertility Care Center are providing technical assistance.

Nepal's guidelines, provider manual and training curriculum soon will be completed. "They will represent the most comprehensive resource materials for reference and training in family planning service delivery in Nepal," says Dr. Shyam Thapa, FHI senior scientist and technical adviser to the

Ministry of Health in Nepal. "They not only fill a long-existing gap, but also aim at throwing out the outdated and unnecessary practices that have existed over the last 25 years in family planning programs in Nepal. At the same time, documents take into account the low literacy, particularly among women, and poor health conditions of the country."

An essential component in the development of guidelines is that diverse agencies, which may have different points of view, agree on country-specific guidelines, says Dr. Thapa. "This is critical in avoiding confusion and maintaining consistency no matter which agencies are assisting with preparation of the documents, organization of training courses and implementation of programs," he says. (FHI's *Catalogue of Family Planning Service Delivery Guidelines* showed differences when guidelines from one organization were compared with another.)

Since 1987, efforts to develop and refine guidelines have been under way in Africa, where INTRAH has helped individual countries develop family planning service policies, standards, and procedures. In Uganda, for example, INTRAH worked with national experts to develop standards, policies and procedures, which included a new category of family planning service provider. A Demographic Health Survey study showed that 85 percent of the population knew about family planning, but only 5 percent used contraception. The reason frequently given for non-use was that methods and services were difficult to obtain, particularly in rural areas. A group working to develop guidelines recommended that nurse aides be trained in family planning, including distribution of pills and injectable contraceptives.

Whether writing national guidelines for the first time or updating existing guidelines, providers and policy-makers emphasize that the process should incorporate the ideas and opinions of many diverse groups, including representatives of women's groups and nongovernment organizations.

Wilson, a USAID clinical specialist, says diversity is a key to the successful implementation of guidelines. "The more we can get people to be part of the process, the more likely we are to have a successful outcome. It takes longer and that can be frustrating, but what you have to show for it in the long-run is a much broader base of support. Guidelines are more likely to be used if more people are involved. You don't want to be elitist or exclusionary."

## DISTRIBUTE GUIDELINES

Writing or revising guidelines is only one step in a long process. Once national guidelines have been written, they must be distributed and policy-makers and providers must be educated about their contents and their usefulness. This education, which may include mailings, workshops or training sessions, should include all levels of providers and all geographic areas, says Dr. Rivera of FHI.

"When we have a set of guidelines, even if we try to frame those guidelines within quality of care, it doesn't mean things are going to change dramatically," said Dr. Huezio of IPPF. "First, you have to make sure the guides are going to be used at the service delivery level. Nothing is going to change unless service delivery providers and program managers are motivated to improve their performance and to look at the clients in another way — at the needs and rights of the clients."

In the Caribbean island nation of Jamaica, national service delivery guidelines were developed in 1991 by the Ministry of Health and the National Family Planning Board (NFPB). Due to funding constraints, guidelines were not widely distributed to public or private physicians.

A survey of 367 private Jamaican physicians, conducted last year for the NFPB with assistance from FHI, showed wide variations in service delivery practices. For example: Nearly 40 percent of physicians said women should stop using the IUD at age 40, and 91 percent said women should have at least one child before using injectable contraceptives,

although there is no scientific rationale to restrict age or parity. More than half the doctors required parental consent before giving contraceptives to teenagers. And nearly two-thirds recommended a "rest period" for women using the pill, IUD or injectable contraceptives.

"A client seeking service from different providers may be given a method by one provider and not by another," said the authors of the report. "While it is clear that each individual client must be screened according to his or her own circumstances and conditions, more consistency of care may be warranted islandwide."

The authors of the report have suggested that Jamaica's service delivery guidelines could be updated to provide protocols on each contraceptive method. And authors recommended that training curricula could be reviewed to ensure consistency with service delivery guidelines.

As part of the effort to improve quality of care, standardized guidelines can be useful in training providers and evaluating the job performance of health workers and supervisors.

"Without standards, supervision is very subjective and is based on personal experience and intuition," says Dr. Alain Damiba of JHPIEGO, who has helped develop service delivery guidelines in Burkino Faso, Cameroon, Rwanda and Togo. "With standards, you can tell the provider 'This is what is expected.'"

After national guidelines are written and distributed, they must continually be reviewed to incorporate new information.

"This is not only important to eliminate unnecessary practices but to strengthen those practices that are necessary for quality care, such as screening for sexually transmitted diseases among IUD users," says Dr. Hardee of FHI.

"Quality is the reason guidelines are updated," says Dr. Rivera of FHI. "The scientific knowledge changes, the financial and human resources change, the societal expectations change. This is definitely a process. You cannot expect you will do everything the first time."

— Barbara Barnett

## FOOTNOTES

1. World Health Organization. *Improving Access to Quality Care in Family Planning: Medical Criteria in Selected Methods of Contraception*. Draft report. (Geneva: WHO, July 1994), 5.

2. Interagency Guidelines Working Group. *Recommendations for Updating Selected Practices in Contraceptive Use, Volume One*. Draft. Washington: USAID, May 20, 1994.

3. Bailey W, McDonald OP, Hardee K. *Family Planning Service Delivery Practices of Private Physicians in Jamaica: Final Report*. Family Health International: Research Triangle Park, May 1994.

PHYSICIANS, NURSES AND OTHER HEALTH PROVIDERS THROUGHOUT A COUNTRY MUST BE ADEQUATELY INFORMED ABOUT NATIONAL GUIDELINES IN ORDER TO USE THEM. THIS HEALTH WORKER EXAMINES A PATIENT NEAR SAN IGNACIO, BELIZE.



SEAN SPRAGUE/IMPACT VISUALS

# Method Choice Involves Many Factors

Client fears or misunderstandings are among considerations when choosing a contraceptive method.

MANY CLIENTS FIND IT DIFFICULT TO QUESTION THE AUTHORITY OF PHYSICIANS, MAKING IT IMPORTANT FOR PROVIDERS TO ENCOURAGE THEIR CLIENTS TO DISCUSS THEIR FEARS AND CONCERNS. A PHYSICIAN AT A FAMILY PLANNING CLINIC IN CAIRO TALKS WITH A PATIENT.

Choice of contraceptive method depends on many factors, including the age and health of a client, the willingness of the client's partner to participate in family planning, sexual behaviors of both partners and a careful review of the risks and benefits involved with each available method.

To help couples make an informed choice, providers need the latest scientific information on health risks and benefits. They should also understand how most clients are likely to perceive the risks and benefits of a method, since perceptions are often shaped by cultural surroundings and may be formed from incorrect information.

Traditional risk-benefit models estimate the risk of dying in using a particular contraceptive method. While these findings influence such factors as regulatory decisions

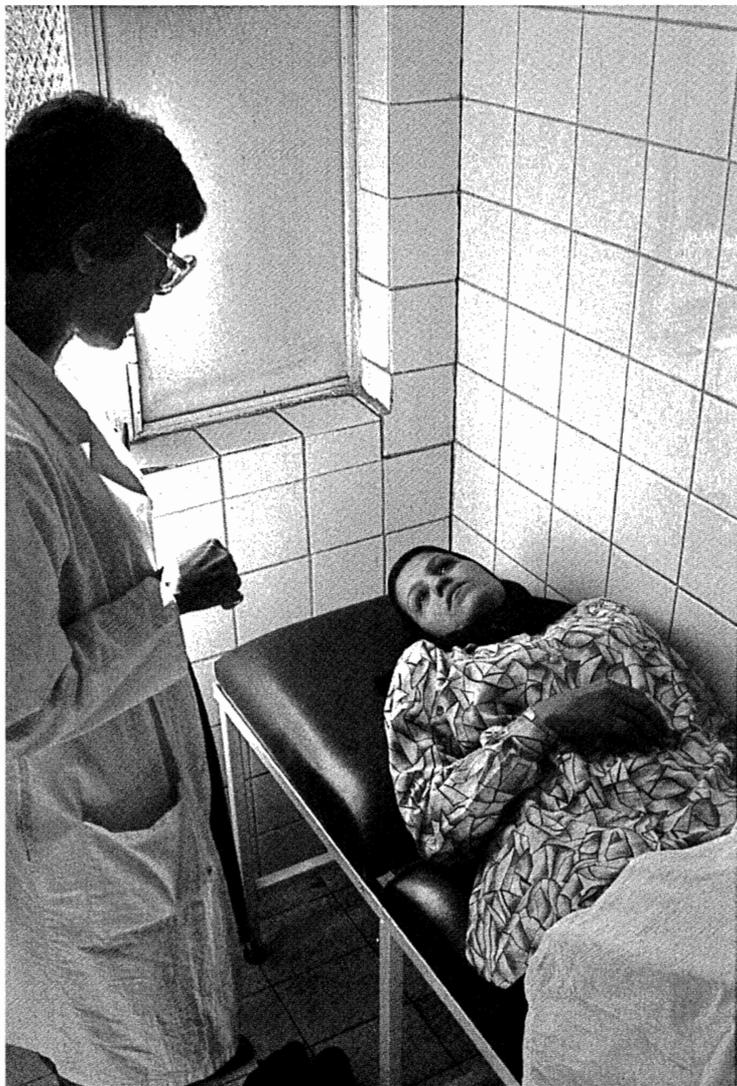
on new methods, national guidelines and training curricula, they do not take into account a person's actual perception of risk. In fact, the small risk of death due to using any contraceptive method is one of the least important factors affecting an individual's choice of method.

"The crux of the matter is how the scientific information is interpreted by the couple making the decision," says Dr. Willard Cates, FHI's corporate director for medical affairs. "The goal of providers should be to help each client to select a method that is safe and that can be used without fear."

Experienced family planning providers point out the complicated ways that perceptions of medical and psychological risks affect service delivery. "We try to correct myths during training programs conducted for doctors and field-workers," says Dr. Sriani Basnayake, medical director of Sri Lanka's Family Planning Association. "We always stress the point that they should address myths and allay the fears of clients even if the client does not specifically refer to such myths."

But this can also reinforce the idea that providers know best what clients need. "Providers often have different perceptions from clients and often assume that their views are correct because of their training," says Dr. Basnayake. "Sometimes providers working in the field for a long time tend to forget the doubts, fears and perceptions of the public."

Many factors are involved in correctly assessing the risks and benefits involved in using various methods, including providers' attitudes, counseling, nonmedical factors and medical issues.



NASH HERNDON/FHI

## PROVIDERS' ATTITUDES

Physicians' views of contraceptive methods have a pivotal impact on family planning acceptance and use. Physicians are the leading providers in many clinics and the only providers for long-acting methods in most countries. Even though nurses and paramedics increasingly provide clinical services and community-based distribution systems have expanded, their views and actions are often heavily influenced by those of physicians.

Physicians also influence the development of national policies and delivery guidelines, educational and training curricula, and management practices. Studies indicate that physicians have misperceptions about risks and hold attitudes that limit the availability and use of some methods, particularly long-acting methods. The views of public health nurses and other providers can also limit contraceptive choice.

A study among 660 physicians in São Paulo, Brazil found that they viewed vasectomy as a valid method for themselves (11 percent used it, compared to 2 percent of the general population). But they did not generally recommend it to couples because they presumed that men would not want it. A population-based survey, however, indicated potential interest in the method. "The high level of acceptance of vasectomy among physicians stands in stark contrast with what they perceive to be the attitudes of the general male population," explains Dr. Patricia Bailey of FHI, who led the study.<sup>1</sup>

Physicians' attitudes can limit the public's choice of methods, even though their biases may be based on wanting what the providers perceive as best for clients. A study of 375 physicians in Mauritius, Peru, Sri Lanka and Philippines found that they favored "good, scientific and useful" methods. This phrase was one of nine factors identified by the physicians as determinants of their attitudes towards various methods. The other factors included cost, health risk, cultural and religious issues, ease of correct use, and impact on the couples' relationship.<sup>2</sup>

"What a potential consumer believes to be true about contraceptive alternatives often depends upon the information provided by the physicians," explains Dr. Lawrence Severy, who conducted the four-country study. "But patients may have different perceptions of the methods and might reach different decisions from those of their physicians about which methods to use."

In Kenya, overall contraceptive use is increasing, but the proportion of those choosing IUDs is falling. A preliminary analysis found that bias against the method by providers is the single most important

constraint to growth of IUD use, says John Stanback of FHI, who directed the analysis and has begun an in-depth study of the issue. Other factors affecting IUD use include lack of commodities, fear of HIV transmission, product image and packaging, and shifting client preferences. Public health nurses as well as physicians can provide IUDs in Kenya.

A recent study in Ghana found that providers' attitudes toward methods limit clients' access. Some providers believed incorrectly that Norplant and injectables lead to permanently reduced fertility. About 40 percent required a woman to be married before getting an IUD or injectables; 26 percent took that view regarding pills. Provider bias was also present against condoms, spermicides and male sterilization.<sup>3</sup> Because of the small number of physicians in Ghana, public health nurses deliver most family planning services. The Ministry of Health is assessing how these attitudes can be brought into line with current scientific information in order to increase contraceptive use.

## COUNSELING NEEDED

Questioning the authority of providers is extremely difficult, especially if the provider is a physician. Some providers acknowledge such issues and recognize the importance of listening to clients' fears and views.

At a 1992 meeting in Istanbul, Turkey, 60 health-care professionals from 25 countries discussed the role of counseling in family planning. Counseling involves a two-way communication between providers and clients, the group concluded, and it assists clients in making "informed, well-considered, voluntary decisions about their fertility and their use of contraceptives." But research is needed, the leaders of the meeting concluded, "to assess the impact of counseling on acceptance of contraceptives, continuation of use and satisfaction with methods among clients."<sup>4</sup>

Several studies do suggest that counseling can reduce discontinuation rates. An FHI study in two West African countries, Niger and The Gambia, found that discontinuation of method use after six to eight



DR. SRIANI BASNAYAKE OF SRI LANKA FAMILY PLANNING ASSOCIATION.

months was substantially higher among new family planning clients who felt they did not receive adequate counseling than it was among those who felt they had.

Among 540 women in Niger, 37 percent of those who felt they received poor counseling discontinued use compared to 19 percent of those who felt they had adequate counseling. Among 410 Gambian women, 51 percent of those who felt they did not have good counseling discontinued compared to only 14 percent of those who felt they were well counseled.<sup>5</sup>

"While these studies suggest an association between counseling and continuation, they were focused on tracking discontinuation and relied on retrospective judgments by women on the quality of the counseling," says FHI's Stanback, study monitor. "Prospective studies on the relationship of counseling to continuation rates are necessary in order to draw a more scientific conclusion."

An FHI-sponsored study in Bangladesh attempted to accomplish this, by measuring the impact of counseling husbands as well as wives. Researchers found that a woman used the implant Norplant longer when husbands were included in the counseling at the beginning and learned that the method could cause irregular menstrual bleeding.<sup>6</sup>

Training providers to counsel clients about contraceptive options rather than steer clients towards specific methods might help clients choose methods they will be comfortable using — and will continue to use.



BERYL GOLDBERG

A HEALTH PROVIDER'S PERSONAL VIEWS ABOUT A CONTRACEPTIVE METHOD CAN PLAY A SIGNIFICANT ROLE IN SHAPING THE CLIENT'S BELIEFS ABOUT THE RISKS AND BENEFITS INVOLVED. THIS FAMILY PLANNING PROVIDER DISCUSSES CONTRACEPTIVE OPTIONS WITH A MOTHER AT A CLINIC IN MEXICO CITY.

A study in Nepal tested the imbalance of power over choice of contraceptive method between a provider and a client. The researchers trained typical clients to ask providers certain questions and analyzed what happened. Lower-class clients, despite this training, were extremely uncomfortable seeking information beyond what the doctor offered. Providers therefore were in a position to limit contraceptive choice, the study concluded, "especially when the clients or prospective clients are lower-class, or low caste or uneducated."<sup>7</sup>

Besides training providers in counseling, providers could use simple "yes" or "no" questionnaires to understand clients' fears and perceptions of particular methods. Verbal or written questions could address experiences with contraception, feelings about a method, how a method will affect the partner's feelings, its impact on lovemaking and other issues.

Certain questions will be more important, depending upon the setting. In Sri Lanka, for example, Dr. Basnayake says the most important questions would be: Are you afraid of using the method? Will you have trouble using the method correctly? Are there still unanswered questions about the method? Is your partner opposed to this method?

#### NONMEDICAL FACTORS

Even where counseling is used, it often focuses on information such as contraceptive side effects and proper use. This information can decrease the fears a client has about a method, but counseling needs to go further and address many important risks due to nonmedical factors.

In a study of gender and reproductive decision-making in rural Bangladesh, Dr. Nancy Stark identified some of the cultural risks women face in using contraception.<sup>8</sup> "Some women were afraid of being beaten if their husbands learned they were using contraception," says Dr. Stark, technical adviser on gender issues to USAID. "They also had to be very careful about the impact of side effects — not just on their reproductive functions but on their social world. If they had repeated, irregular bleeding, they would not be able to cook if they are Hindu or pray if they are Muslim."

Such factors have a major effect on contraceptive choice. For example, a woman might use injectables without her husband's knowledge but might experience irregular bleeding. In contrast, she might be able to use the pill with fewer obvious side effects, but her husband might find the pill packets in the house.

Providers in such situations need to be familiar with the women's overall lives as much as with the latest medical findings. "Women are concerned about controlling their fertility without getting into trouble

with their husbands and in-laws," says Dr. Stark. "We need to broaden the idea of risks and benefits of contraception to examine the broader risks that women encounter. We need to know what risks they perceive in using contraception."

Few data thus far, however, address how contraceptive use might increase the risk of domestic violence or other family trouble. FHI is exploring ways to analyze such connections between contraceptive use and women's lives.

In the Philippines, working with the University of San Carlos in Cebu and the University of North Carolina in the United States, researchers are interviewing 2,800 Filipino women on family planning knowledge and use, family decision-making, and women's work and status. In-depth interviews will be conducted with a subset of 120 women on life events, couple dynamics, status and aspirations, influences of family planning on life choices and quality of life. The women in the survey have been part of the Cebu Longitudinal Health and Nutrition Survey, with data extending back to 1983.

"We are interested in finding out what types of risks women might attach to using a contraceptive method and how those risks affect them," says Dr. Eilene Bisgrove of FHI, who is working on the study. "We are asking how side effects have affected them and perhaps, their family and work, and what they have heard about a method. We need to bring these types of questions into the realm of risk assessment."

#### MEDICAL ISSUES

Scientific research on contraceptive methods continues to yield new information, and providers need to have up-to-date training on the latest medical findings. This helps providers address clients' misperceptions about a method, such as fears that oral contraceptives cause cancer.

"Misperceptions about the risks of oral contraceptives persist in Sri Lanka," says Dr. Basnayake. She participated in a 1987 study, which found that clients thought — incorrectly — that the pill caused "substantial health risks." Studies in the United States have had similar findings, including one in 1993 among well-educated, urban women.

As scientific information on methods changes, new evaluations of the health risks and benefits of that method may be necessary. Also, new factors affect risks and benefits, especially the increased threat of STD/HIV infection. New scientific findings should be incorporated into policies, regulations, service delivery guidelines, training, and approaches to service delivery.

## FAMILY, PSYCHOLOGY PLAY IMPORTANT ROLES

*Margaret Thuo, program manager of the Family Planning Association of Kenya (FPAK), describes how FPAK addresses clients' perceptions of risks from contraceptive methods.*

Fears about the pill have centered on findings that it can increase the risk of death from cancer and cardiovascular disease among some groups. Many providers think, incorrectly, that any woman over age 35 or any woman who smokes should not use the pill. However, FHI researchers found in a 1994 risk-benefit study, using U.S. data, that the risk of death from pregnancy is higher than the risk of death due to cardiovascular disease among low-dose pill users of all ages, except for the heaviest smokers 30 years of age and older.

"The public health message from this study is clear," says Dr. Pamela Schwingl, FHI's lead scientist on contraceptive safety. "If you are a heavy smoker, you should not use oral contraceptives if you are over the age of 30. Under that age, if you use the pill, you should think seriously about stopping cigarette smoking so you are not a heavy smoker when cardiovascular risk increases."

The study analyzed the risk of death due to cardiovascular disease for users and nonusers of oral contraceptives, according to age groups and amount of smoking (heavy, light and none). Heavy smoking was 25 or more cigarettes per day. It compared the findings for each category (for example, a heavy smoking pill user, 40-44 age group) to the risk of death due to pregnancy for a non-contracepting woman in the same age group.<sup>9</sup>

FHI is analyzing the risks and benefits of pill use at various ages for women in Jamaica and Costa Rica. Both countries have high contraceptive prevalence rates, including high pill use. Study results should be available in 1995.

"We conducted these studies in order to analyze risks and benefits for specific developing countries," says Dr. Schwingl. "Previous modeling studies have been done in developed countries, where many factors are different. If these countries have higher rates of disease, it may change the risk-benefit equation, depending on the availability of health-care facilities and other factors."

These risk-benefit models provide "an excellent way to integrate current information on the beneficial effects of the pill — pill use decreases chances of endometrial and ovarian cancers — and the potentially harmful effects," says Dr. Schwingl. "But the findings must be considered in conjunction with women's perceptions of risk and with their overall life situation."

— William R. Finger

Many people in Kenya have beliefs about contraceptives that are based on psychology and family issues. Recognizing this, we train service providers on counseling and listening skills as well as on contraceptive technology. Providers are encouraged to learn from clients and to respond with sympathetic understanding.

Some clients think that pills give smooth skin to women, that injectables make a woman fat (a sign of beauty for some), that vaginal foams clean the birth canal and that tubal ligation can help a woman enjoy sex more.

Others believe, however, that tubal ligation makes the body of a woman cold and hence she cannot enjoy sex.

Others believe that the string of an intra-uterine contraceptive device (IUD) can hurt their partner or that an IUD can travel to their hearts. Others believe that an injectable contraceptive makes a woman sterile.

Some risks that clients identify are influenced by their family, particularly their mothers-in-law. Some family members believe that contraceptives make a woman wild or sexually overactive. Others, including clients themselves, believe that taking contraceptive pills causes some women to have twins or triplets.

Listening to clients and building rapport and confidence are important. Service providers need to take enough time with

each client to ensure that her fears are addressed. Counseling is essential for new clients, and reassurance continues to be important during follow-up. When a woman chooses a method but has problems with her

CEDPA



MARGARET THUO

in-laws, marital counseling and support from her husband and family are helpful. In such situations, confidentiality is the key to success.

Community-based distribution agents and clinic providers can respond to many client concerns. These include the ways that contraceptives affect sexuality, health and other sensitive and private matters. Clients who do not want their partners to know they are using contraceptives can also be assisted.

To discover clients' attitudes and feelings towards contraceptives, the FPAK conducts occasional profiles of users and nonusers and has focus group discussions. This helps us design communication programs that are relevant to clients' needs. In 1988, for example, we conducted focus group discussions on rumors about contraceptives and on what men know about contraceptives. As a result, we developed booklets on "Facts About Contraceptives" and "What Every Woman Should Know" which continue to be a great help to the FPAK in providing facts about contraceptives and related concerns.

— Margaret Thuo

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# FHI's Role at the Cairo Conference

CAIRO, Egypt — The United Nations 1994 International Conference on Population and Development (ICPD), held September 5-13 in Cairo, Egypt, brought together more than 20,000 government leaders, diplomats, women's advocates, scientists, and journalists to debate a critical subject: How to curtail the world's rapid population growth and what role economic development should play in population issues.

This is the third time the United Nations has convened such a conference. The first was held in 1974 in Bucharest and the second in 1984 in Mexico City. This year's conference resulted in a 113-page document that outlined how the 180 countries attending should proceed on population and development issues during the coming decade. A consensus was achieved on many fronts, although about 20 nations registered reservations about some of the language, such as passages involving abortion.

In its role as an international research organization that promotes better reproductive health, Family Health International sent a team of 10 experts to the concurrent Non-governmental Organization (NGO) Forum, held in a stadium within a short walk of the ICPD. At the NGO Forum, FHI scientists led workshops, staffed an information booth and gave media interviews in an effort to provide the most current scientific information available on a variety of family planning, women's health and STD prevention topics.

While ICPD delegates were defining global population policy for the next decade, the NGO Forum provided an excellent opportunity for the exchange of ideas and information among hundreds of international and grass-roots organizations, people who are involved daily with family planning programs, contraceptive technology research, and women's health activities.

## FHI'S ACTIVITIES

The articles appearing in this section of *Network* are based upon FHI's chief contribution to this dialogue, the four FHI workshops held at the NGO Forum. FHI's strategy for participating in the forum included the following:

- Three panel discussions on women's reproductive health, planned well in advance of the conference, were led by FHI experts. One panel explored the effectiveness and acceptability of barrier contraceptive methods. Another discussed the merits and challenges of integrating family planning and STD services. The third panel focused on women and AIDS.

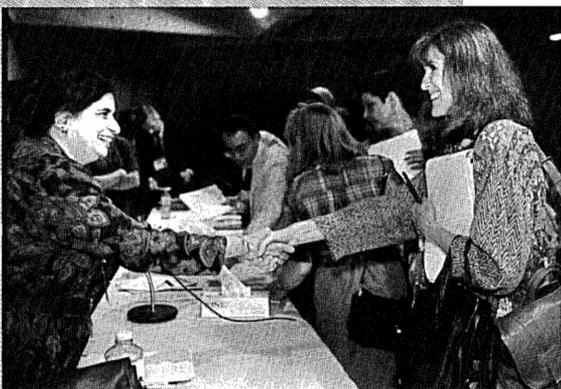
- After the forum was already under way, the FHI team assembled a fourth panel to provide an overview of contraceptive methods. The need for such a workshop became clear as FHI staff encountered numerous myths and incorrect views about contraceptive risks and benefits.

- Throughout the forum, FHI maintained an information booth that gave participants a chance to meet individually with experts and to obtain a variety of printed information, including FHI's new monograph on barrier contraceptive methods and issues of *Network* in English, French and Spanish. One-page fact sheets on specific contraceptive methods, prepared specifically for Cairo, were also distributed in English.

- During the forum, FHI experts frequently answered media questions about contraceptive technology and AIDS prevention.

FHI selected the themes of its workshops carefully. In the United Nations' three preparatory meetings leading up to the ICPD, women's health advocates had emphasized that family planning should be viewed not as one isolated service, but as a component within a spectrum of women's reproductive health services. With the

PEOPLE ATTENDING AN FHI WORKSHOP AT THE NGO FORUM IN CAIRO MEET INFORMALLY WITH PANEL MEMBERS AFTER THE SESSION. DR. POURU BHIWANDI OF THE FHI PANEL, LEFT, GREETES A MEMBER OF THE AUDIENCE.



DONNA DECESARE

ever-increasing incidence of HIV, women's health advocates asked for information about contraceptives that prevent sexually transmitted diseases, as well as pregnancy. They urged scientists to develop barrier methods that do not depend on the cooperation of a male partner or require a visit to a health provider.

With these messages in mind, FHI defined its role as that of resource for information and education on family planning, women's health and STD prevention. The need for information and education was viewed as critical. The ICPD's final document would define global population policy objectives for the next decade, which would guide family planning programs, contraceptive technology research, and women's health activities throughout the world.

### THE ICPD PROCESS

When ICPD delegates gathered the first day of the meeting, their task was to approve a 16-chapter "Programme of Action." The document had been drafted at previous preparatory meetings and covered a wide range of issues, including gender equality and women's empowerment; population growth; the relationships among population, economic growth and sustainable development; international migration; in-country migration of people from rural to urban areas; and technology, research and development. While most of the text was considered noncontroversial, portions of Chapters 7 and 8 drew close scrutiny and stirred the most emotional debate.

Chapter 7 defined reproductive rights and reproductive health and stated that men and women should have access to "fertility regulation" methods. The Holy See and some of the Islamic states joined forces to oppose this paragraph, saying it implied a right to abortion. The final document replaced the term "fertility regulation" with "family planning" and "regulation of fertility," emphasizing that family planning activities within a country must comply with that nation's laws.

Chapter 8, entitled "Health, Morbidity and Mortality," addressed the issues of child survival and health, women's health and safe motherhood, and AIDS. Throughout most of the conference, debate centered on the 25th paragraph in Chapter 8, concerning the impact of unsafe abortion on maternal health. Catholic and Islamic leaders opposed this paragraph, saying it would encourage abortions. An example of the intensity of this debate could be seen in an effort by several women's groups to draw attention to other important issues affecting women. Because

the abortion debates had received such extensive media coverage, the women's groups held a press conference to discuss non-abortion issues of relevance to women. The meeting, however, ended with confrontation as abortion opponents vigorously debated the issue with speakers.

Compromise language in the final document states that "in no case should abortion be promoted as a method of family planning" and that the incidence of abortion should be reduced by expanded access to family planning programs. The document urges public and private organizations to remedy the health problems caused by unsafe abortion and says that in countries where abortion is legal, it should be safe.

### CLEAR IMPLICATIONS

On the afternoon of September 13, the ICPD formally adopted the Programme of Action.

There are clear implications for family planning providers, program managers and policy-makers working in developing countries:

- Women, who have traditionally been the recipients of family planning services, are demanding to play a more active role in the development and management of family planning services. The ICPD document embraces this concept.

- The document supports the idea that family planning services should be viewed as part of women's larger reproductive health needs, including treatment of reproductive tract infections and STDs. The Programme of Action defines reproductive health as a state of complete physical, mental and social well-being, not just an absence of disease. It affirms the "right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice."

- Because women are culturally and economically disadvantaged in many areas of the world, they are particularly vulnerable to STDs and AIDS. The ICPD document calls for more research on female-controlled barrier methods, such as vaginal microbicides, as well as research to find an AIDS cure.



CARLOS CONDE/IDB

BOYS AND GIRLS STUDY TOGETHER AT A SCHOOL IN EL CHIPE, ECUADOR. THE ICPD PROGRAMME OF ACTION AFFIRMED THE IMPORTANCE OF THE EDUCATION OF GIRLS IN GLOBAL LONG-TERM EFFORTS TO IMPROVE WOMEN'S STATUS AND HEALTH.

- Men should be responsible for their own sexual health and fertility, the document says. Adolescents should receive information and access to family planning and reproductive health. Providers should not restrict access to services and should respect young people's confidentiality and privacy.

- The ICPD document recommends that family planning be formally and informally linked with development activities, such as income-generation activities for women and better education of girls. The ICPD Programme of Action says that population programs must be integrated into economic and development programs to eliminate poverty and improve quality of life. Women's ability to control their fertility is called a "cornerstone" of population and development programs.

Now that the ICPD has ended, the next step for NGOs is to consider how to take the far-reaching policies developed at the ICPD and implement them in cities, communities and villages in their home countries.

— Barbara Barnett

# Empowering Women May Help Retard HIV



HIV infects nearly as many women as men worldwide, with 3,000 new infections among women each day.

By Dr. E. Maxine Ankrah

Senior Adviser, Women's Initiative, FHI AIDS Control and Prevention Project

CAIRO, Egypt — Improving women's status through education, greater access to employment and credit, and expansion of legal rights not only leads to better use of family planning, but could also help slow HIV transmission. As the number of women with HIV and AIDS continues to rise rapidly, we are beginning to understand how social and economic inequities make women particularly vulnerable to HIV infection.

In many societies, women's limited access to education, employment and credit jeopardizes their ability to protect themselves from HIV/AIDS. Many women are often unable to say "no" to unwanted or unprotected sex, in part because of their economic dependence on men. As a result, HIV/AIDS is growing faster among women — particularly young women — in many countries.

Ultimately, changes in gender relations will depend on the success of long-term development efforts to improve women's status. AIDS, in turn, affects development. Because of women's crucial role in agriculture, trade, child rearing and family support, the rapid spread of HIV among women may hamper economic and social development in many parts of the world.

While the AIDS epidemic was not a primary focus of the International Conference on Population and Development, the conference delegates recognized that HIV is a threat to sustainable development and a critical women's health problem. An action statement adopted by the delegates calls for comprehensive reproductive health services that improve access to a wide range of contraceptive choices while also helping women protect themselves from HIV and other sexually transmitted diseases (STDs).



DR. MAXINE ANKRAH

## THE SHIFTING EPIDEMIC

The World Health Organization estimates that 3,000 women become infected with HIV every day. By the year 2000, over 13 million women will have been infected and 4 million of them will have died.

These numbers reflect a shift in the global epidemiology of HIV/AIDS, according to Eka Esu Williams, president of the Society for Women Against AIDS in Africa, who was among panel members at an FHI workshop on "Women and AIDS" in Cairo. Heterosexual transmission is now the primary mode of transmission in most regions of the world, and HIV infects almost as many women as men worldwide.

In sub-Saharan Africa, where HIV/AIDS began as a largely heterosexual epidemic, more women than men are becoming infected, and young women are now at greatest risk. Cumulative AIDS cases

reported in Zimbabwe among 15- to 19-year-old women between 1987 and 1993 showed that for every case in a young man, there were five cases in young women, Williams told workshop participants. The United Nations Development Programme (UNDP) reports that 70 percent of all HIV-infected women worldwide are ages 15 to 25.

These statistics suggest that women are particularly susceptible to acquiring HIV infection, yet the stereotype persists of a virus spread primarily by homosexuals, injection drug use and sex workers.

AIDS education messages in Thailand have often encouraged misconceptions about women and AIDS, said another panel member, Chantawipa Apisuk, founder of EMPOWER, a grassroots organization that advocates for the rights of sex workers in Bangkok. She described a television message with a well-educated pregnant woman telling her son, "It's a pity for a good woman like me to have AIDS," and a billboard depicting a sexy woman in a negligee holding a condom above the message, "Having Fun Without Risk." Such messages "emphasized that good women transfer AIDS through pregnancy and bad women transfer AIDS through needles and sex," Apisuk said.

Apisuk told the stories of several women living with HIV infection, including a factory worker who was fired from her job because of her HIV status, a sex worker being cared for by her mother, and a pregnant woman who had been married just over a year. "AIDS threatens all women alike," she said.

Recent public opinion surveys show that Brazilians also believe that HIV affects only "people living unconventional, promiscuous sexual lives — prostitutes, male homosexuals and so on," said Dr. Simone Diniz of Coletivo Feminista Sexualidade e Saúde in São Paulo, Brazil.

"In fact, the data we have now shows that this is not the reality," said Diniz, a panel member at the workshop. In São Paulo, AIDS is the leading cause of death among women ages 20 to 35.

## GENDER AND AIDS

Traditional gender roles often deny women the power to protect their health. Since many cultures consider female ignorance of sexual matters a sign of purity, young women are afraid to seek crucial reproductive health information and services. Even after marriage, many women are unfamiliar with their own reproductive anatomy, reluctant to talk about sex for fear of appearing "loose," and unable to recognize STD symptoms.



YOUNG WOMEN ARE AT GREATEST RISK OF HIV INFECTION, ESPECIALLY SINCE HETEROSEXUAL CONTACT HAS BECOME THE PRIMARY MODE OF TRANSMISSION IN MOST REGIONS OF THE WORLD.

Society's expectations for men also increase women's risk of infection, Diniz noted. "In most countries monogamy is required for women," she said, "while sex outside marriage is permitted for men as a symbol of status and virility."

Few women believe they have the power to challenge these expectations. For example, 85 percent of the women interviewed in a recent study in Nigeria said they did not believe they should ask their husbands about extramarital affairs, Williams said.

If a woman's partner has multiple sex partners, her monogamy will not protect her from HIV infection. Abstinence or condom use, however, may not be possible. "The use of condoms raises problems for women: it's the men who must use them, often in situations where women have little or no control," Diniz said. "Women who suggest sex without penetration or sex with a condom often risk violence or even abandonment by their partners."

#### PREVENTING AIDS AMONG WOMEN

Shattering the myth that only women with multiple partners are at risk of HIV infection is the first step toward helping all

women protect themselves. "We also have to address the attitudes of women themselves," Williams said. "We need to change their perceptions of risk."

Men also need to take more responsibility for protecting themselves and their partners, said another panelist, Elizabeth Reid, who is director of the UNDP's HIV and Development Programme. Women and men must work together to improve communication between the sexes and change cultural norms that sanction and even encourage men to have multiple partners.

"Communities and cultures have to start talking about this," Reid said. "Are they going to raise their male children differently? Are they going to raise their female children differently?"

Another important way to help women protect themselves is to provide HIV prevention and counseling services through family planning programs, which reach millions of sexually active women.

"Family planning programs must take on new responsibilities," said Diniz. These responsibilities include HIV/AIDS preven-

tion, women's empowerment and promotion of barrier methods that protect against HIV and other STDs as well as pregnancy.

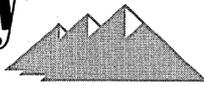
Most primary care for women in the United States is gynecological care, noted Dazon Dixon of Sisterlove in Atlanta, GA, USA. "I don't care where you're providing services to women, HIV should always be part of it," Dixon, a member of the audience, said during a question and answer session.

The HIV/AIDS epidemic can create opportunities to address problems that women have faced for a long time, including economic inequities, violence and sexually transmitted diseases, Dixon added.

"HIV opens up windows on the things that have always been killing us," she said. "HIV has brought them center stage."

*AIDSCAP Science Writer Kathleen Henry attended this FHI workshop, entitled "Women and AIDS," and assisted Dr. Ankrab with writing this article.*

# STD Services in Family Planning Programs



More family planning programs are adding STD services, but evaluating how to do so is complex.

By Lynda Cole  
Director, FHI Field Operations Division

CAIRO, Egypt — Prevention, diagnosis and treatment of sexually transmitted diseases (STDs) is an often neglected area of women's health. Few family planning programs, including those within maternal and child health services, currently provide STD-related services. But this pattern is beginning to change. Increasingly, policy-makers and program managers are considering ways that family planning programs can address a broad range of reproductive health needs including STDs.

A growing number of family planning programs are adding STD-related services in countries as diverse as Botswana, Malawi and Kenya in Africa; Sri Lanka and India in Asia; and Colombia, El Salvador, Brazil and Jamaica in Latin America.

Most programs are focusing on preventive services, providing information about STDs and AIDS, counseling about unsafe sexual behaviors, and promoting condom use, possibly in conjunction with another contraceptive method. A few programs have also added STD management services, which involve diagnosing and treating STDs among clients and the partners of those identified as needing treatment. Some programs are exploring possible collaborative efforts that could include, for example, adding family planning services to existing STD clinics.

There are many challenges to adding STD-related services. Barrier methods are the only type of contraceptives that protect

against STD transmission, but most family planning programs do not promote barrier contraceptive methods because of concerns about their contraceptive effectiveness, client compliance and cost. Thus, many family planning programs have to reorient themselves and give more time and attention to providing barrier methods. Also, STD management requires that programs pay attention to a client's partner, who is also likely to be infected. Most family planning programs focus on women and have difficulty treating male partners.

STDs can be difficult to diagnose, especially among women, and drugs for treatment are expensive and often not available. Even when diagnosed and treated properly, women are likely to be reinfected if their partners do not receive treatment. Many women lack the power in sexual relationships to insist that their partners get treated and that they use condoms during intercourse.

## GRADUAL INTEGRATION

A family planning clinic in a busy market area of Nairobi, Kenya has recently added diagnostic and treatment services for STDs. Since 1988, when the clinic opened, clients have asked about STDs,

and the nurses have responded with information on prevention and referrals to other clinics for diagnosis. Last year, the nurses were trained in STD diagnosis and treatment; this year, drugs were obtained and STD management services began.

"It is important to integrate services gradually starting with simple tasks and adding carefully the most difficult," said Mary Wanjiku Kairu, African regional coordinator for the Centre for Development and Population Activities (CEDPA), a U.S.-based group that provides funding and technical assistance to the clinic.

Training the clinical staff about STDs and AIDS increased their knowledge and confidence, which enhanced their credibility among clients. This helped meet a broader range of women's reproductive health needs and had other benefits as well. "The clinic has created an entry point for motivating groups like men and youth for family planning," Kairu told an FHI workshop at the International Conference on Population and Development in Cairo.

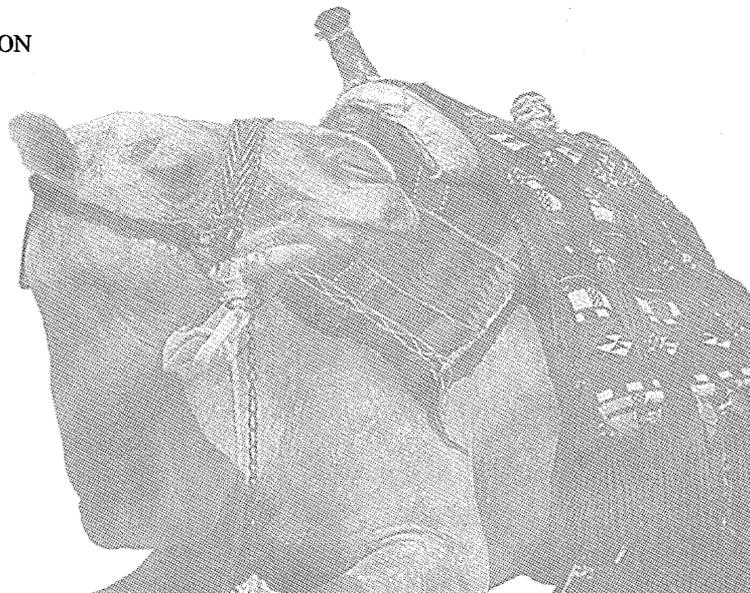
Sponsored by Family Life Promotion and Services (FLPS), the clinic targets low-income workers operating small shops, as well as groups with a high risk for HIV infection such as truck drivers and commercial sex workers. It sponsors 60 outreach volunteers working in bars, brothels, small shops and other social settings. Among the 31,400 new family planning clients served from September 1991 through March 1994, 57 percent used condoms, a very high percentage for a family planning clinic. About one-third of the condoms were distributed by the outreach workers.

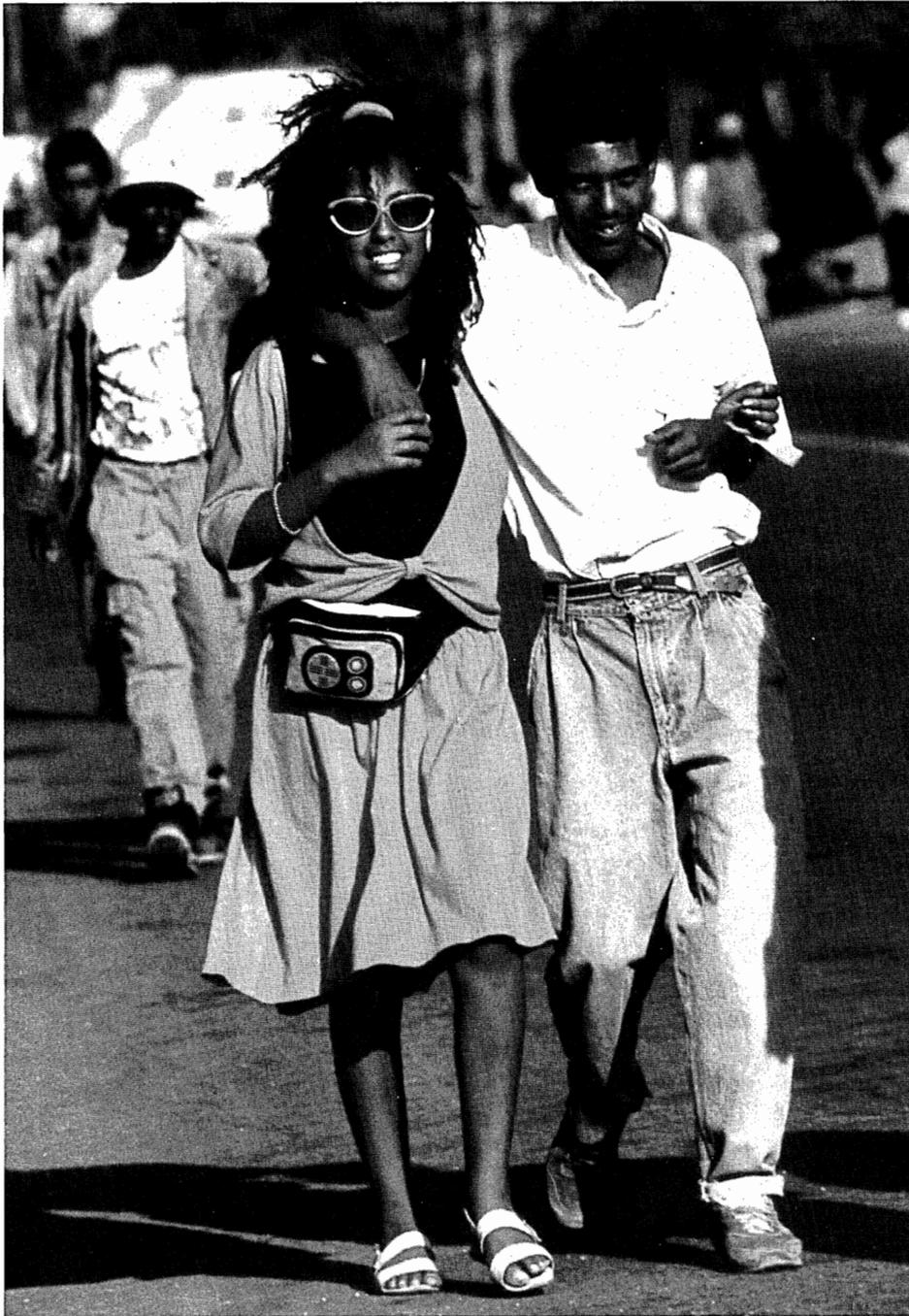
In its first five months of STD management, the clinic diagnosed and gave drugs to 121 patients, 5 percent of all clients served at the clinic. Most were women, and almost one-third received treatment for gonorrhea,



LYNDA COLE

NASH HERNDON/FHI





L. GUBB/WHO

AN ETHIOPIAN COUPLE ENJOYS BEAUTIFUL WEATHER DURING A WALK. MORE FAMILY PLANNING PROGRAMS ARE CONSIDERING HOW TODAY'S LIFESTYLES REQUIRE A BROAD RANGE OF REPRODUCTIVE HEALTH SERVICES, INCLUDING STD PREVENTION COUNSELING AND TREATMENT.

which is not easy to diagnose among women. To make a diagnosis, the nurses follow a flow chart based on the signs and symptoms of a client. Basing treatment on syndromes requires only limited training and can be used without ready access to laboratories,

which are needed to identify the causative organism of most STDs but are prohibitively expensive.

#### ARE SYNDROMES ACCURATE?

The syndromic approach is still relatively new, and its effectiveness in various settings has not yet been evaluated thoroughly. Some syndromes call for treatments of more than one infection, which requires

knowledge of prevalence of various infections in the area. A significant drawback of the approach is that some STDs cause no recognizable symptoms in women. For these women, an accurate diagnosis requires the use of laboratories and microscopes.

Recent studies suggest that adding STD diagnosis and treatment services to family planning programs can be beneficial. They also show that management of STDs is a substantial step beyond the simple steps of prevention counseling and encouragement of condom use. STD management requires more skills, more equipment and more money.

There are advantages and disadvantages to adding STD management to family planning and maternal and child health clinics. A program in which every clinical provider diagnoses and treats STDs requires extensive training and, consequently, a significant initial outlay of funds. But such an approach may also provide more effective services. Partners might also be treated, thus breaking a cycle of infection and saving money in the long run by eliminating reinfection and the cost of future treatments.

Finding ways to reach men with STD messages and services is also important. Couples can be encouraged to come together for family planning and STD counseling. Educational materials can be directed at men.

Because of the complexity and cost of integrating STD services into family planning, it is important to evaluate these efforts carefully before integrating services on a large scale. Integration of services may be worth the resources if it can reduce the incidence of STDs or increase the number of satisfied family planning clients.

Balancing the many issues involved is difficult. All experts agree that starting small is important, as well as knowing how serious the STD problem is among family planning clients and which STDs they have. Cost recovery is an important factor to consider, especially for essential drugs. Assessing the attitudes of the family planning staff and clients about adding STD services would also be useful for program managers considering such changes.

*Science Writer William R. Finger attended FHI's workshop "Family Planning and STDs" and wrote this article with Cole.*

# Barrier Methods Serve Dual Purpose



The oldest group of contraceptive methods is also the only category that protects against STDs.

By Dr. Paul Feldblum  
Deputy Director, FHI Contraceptive Use and Epidemiology Division

CAIRO, Egypt — Barrier contraceptive methods protect against both pregnancy and sexually transmitted diseases. Yet often they are shunned by family planning clients, who incorrectly believe that barrier methods cannot be effective.

Barrier methods are among the oldest methods of family planning and offer the only category of contraceptives that protects against sexually transmitted diseases, including AIDS. They have no systemic effects (they do not affect the entire body) and may be used by people who cannot use or do not want to use other methods. Using barrier methods can be a

good option for people who have infrequent intercourse, since the methods need only be used when intercourse takes place. And some female barriers can be used entirely without the male partner's knowledge.

In Kenya, where the contraceptive prevalence rate is 33 percent, vaginal foaming tablets (VFTs) containing the spermicide nonoxynol-9 have become popular among some family planning clients, Margaret Thuo, program manager for the Family Planning Association of Kenya (FPAK), said at FHI's workshop on barrier methods at the International Conference on Population and Development in Cairo.

In 1993, providers distributed more than 400,000 tablets; this year the number may rise to 600,000. Most of the foaming tablets are distributed through community-based (CBD) programs. "CBD workers distribute, on average, eight times more foaming tablets than do clinic providers," Thuo said.

FPAK, in cooperation with FHI, conducted a 1992 survey of providers and clients. "For many of the users and former users interviewed, VFTs were used either because of problems with other methods or because VFTs were appropriate to their lifestyles," said Thuo. While many women used tablets because they experienced side effects from oral contraceptives, intrauterine devices or injectable contraceptives, others said they had sex infrequently and preferred a contraceptive that was used only during intercourse. In a follow-up study, women who discontinued the

method said their male partners' complaints of too much vaginal wetness or itching influenced their decisions.

Providers should not discount the psychological and social reasons for barrier method use, Dr. Pouri Bhiwandi, a practicing gynecologist formerly with FHI, said at the workshop. "As health care providers, we tend to focus on efficacy. Women do not always put efficacy as the number-one priority," she said. Convenience and ease of use are among a typical client's priorities, she said.

## CONTROLLED BY USER

One advantage of barrier contraceptives is that they are controlled by the user. In Brazil, that is one of the reasons why the diaphragm has become the contraceptive of choice for clients at the Coletivo Feminista de Sexualidade e Saúde clinics. More than 60 percent of the women visiting the clinics for contraception use the diaphragm — approximately 650 women.

"It is empowering women to have control over their reproductive health," said Dr. Simone Diniz, director of the clinics. "We have observed that a woman being able to control her own fertility is a positive metaphor for control over her own life and other decisions." Contraceptive prevalence in Brazil is 66 percent, with most women using female sterilization and oral contraceptives.

Typically the diaphragm is used with spermicide, and one of the disadvantages clients frequently cite is the cost and messiness of spermicide, which must be applied for each act of intercourse. Coletivo clients at a clinic in Belo Horizonte have used the diaphragm without spermicide and found it effective in preventing pregnancy, although experts agree that more study is needed before recommending that diaphragms be used without spermicides. Clients were instructed to wear the diaphragm continuously and remove it only for washing and during menstrual bleeding. The failure rate was 2.4 percent, compared with failure rates of 6.2 percent and 9.1 percent in Coletivo clinics in São Paulo and Campinas where clients used the diaphragm with spermicide.

In the Philippines, where 25 percent of women use modern contraceptives, barrier methods are among the least popular family planning methods, said Dr. Florence Tadiar, executive director of the Women's Health Care Foundation in Manila. Pills, the intrauterine device and female sterilization are the most widely used contraceptive methods, Dr. Tadiar said, because they are the most widely known.

Diaphragm use is rare, and spermicides are not widely available. Condoms are used by some couples — a local organization will even deliver them to a home — but 60 percent of couples discontinue use within the first year. Reasons cited for discontinuation



DR. PAUL FELDBLUM

JULIA BEAMISH/FHI



of condoms and other barrier methods include low efficacy (one out of seven women becomes pregnant the first year of use), lack of availability, and the male partner's disapproval.

Some of the reasons clients give for not using barriers are that they prefer a more convenient or more effective method, that barriers are messy, that condoms tear, that condoms reduce sexual pleasure, the incorrect belief that barrier methods allow only one sexual position, and the perception that condoms are used only for extramarital affairs. Because they are not widely available, diaphragms are not recommended by providers, and providers are not well trained in diaphragm measurement techniques.

#### CORRECT, CONSISTENT USE

Barrier methods work by creating a physical or chemical barrier that prevents intact sperm cells from reaching the female cervix. Physical barriers include the male latex condom and the female polyurethane condom. Chemical barriers contain a spermicidal agent, such as nonoxynol-9, that damages the sperm cell membrane.

A chief advantage of barrier methods — that they are user-controlled — is also a disadvantage. Couples must use the method consistently and correctly during each act of intercourse, and many couples find this difficult. Women may not be able to negotiate use of barriers with their partner. Couples may lack privacy for storing contraceptive supplies. Clinics may not have adequate supplies of barrier methods. A few users experience allergic reactions to latex or to spermicides.

A concern with spermicide use is that local irritation can occur, leading to vaginal and cervical lesions that could, in theory, increase the risk of STD infection. However, the risk of irritation is primarily a concern for women who use spermicides several times a day, such as sex workers. For women who only use spermicides several times a week, irritation occurs in very few users.

Urinary tract infection can be a problem for diaphragm users, but this usually can be remedied by using another size diaphragm. Also, diaphragm users can reduce their risks of infection by urinating before and after intercourse. Toxic shock syndrome is a potentially fatal problem for women who use barriers, but the incidence of toxic shock is extremely rare.

When used properly and consistently, condoms and other barriers are very effective. Use of condoms with a spermicide may offer contraceptive effectiveness that rivals the pill.

Incorrect or inconsistent use are most often the cause of barrier method failure, rather than faulty products. On average, couples who use diaphragms or condoms consistently and correctly can expect 95 percent effectiveness in preventing pregnancy (out of 100 women, five would become pregnant during one year of use).

For disease prevention, correct and consistent use of barriers also is critical. Latex condoms prevent the transmission of STDs, including HIV, but many men at risk of STDs do not use them consistently. Spermicides kill most STD pathogens, and studies are under way to determine whether spermicide use prevents HIV transmission.

Audience members attending the FHI panel discussion raised questions about the efficacy of condoms in preventing disease,

given the fact condoms can break. International studies have shown condom breakage and slippage rates of 0 to 12 percent (most report rates of 3 to 5 percent). A recent FHI study found that failure rates were higher for certain types of users, including people who reported previous condom breakage or those who had no recent experience using condoms.

Research is under way to refine existing barrier methods and develop new ones. These products may increase acceptability and effectiveness, thereby encouraging use among people at risk of contracting STDs.

*Science Writer Barbara Barnett attended FHI's workshop, "Barrier methods and spermicides: what we know about their use and effectiveness," and wrote this article with Dr. Feldblum.*

## WHO SHOULD USE BARRIER METHODS?

### Barrier methods should be considered by

- people at risk of sexually transmitted infections
- men who are prone to premature ejaculation (condoms)
- women who should not use hormonal methods or IUDs, which may include lactating women, women with bleeding disorders, and women in the late reproductive period
- people waiting for another method to take effect (barriers are immediately effective and temporary)
- people who have occasional intercourse
- people who wish to avoid methods that have systemic effects

### Barrier methods should not be used by

- people with allergic reaction or irritation to latex, lubricant, spermicide or spermicide vehicle
- men who have difficulty maintaining an erection during coitus (condom)
- women who have uterine prolapse, retroflexion or anteversion; fistulae, poor vaginal muscle tone; large cystocele or rectocele (diaphragm, cap, sponge)
- women with a history of toxic shock syndrome (diaphragm, cap, sponge)
- mothers who have given birth within the past six weeks (diaphragm, cap, sponge)
- women with a history of repeated urinary tract infections (diaphragm)
- people with certain congenital genital abnormalities

# Confronting Myths With Science



## Lack of contraceptive technology information at NGO Forum motivates FHI to organize panel of experts.

CAIRO, Egypt — At the Non-governmental Organization Forum (NGO) in Cairo, NGOs presented some 400 workshops on issues that affect women and men's lives. They included such diverse topics as reproductive rights, economic development, literacy, and the environment.

Very few workshops held during the 10-day event focused on current and practical information involving contraceptive technology, a topic that directly affects how to achieve the goals of the International Conference on Population and Development.

"Among some people attending the NGO Forum, there was an appalling lack of information as well as a bounty of misinformation about contraceptive methods, their benefits, risks and use," says JoAnn Lewis, FHI senior vice president for reproductive health programs and moderator of the panel discussion on contraceptive technology. "People often draw the wrong conclusions about the efficacy and safety of contraception because they lack adequate information. Policy and advocacy groups have a tremendous impact on family planning service delivery, so if they're misinformed, the quality of client services can suffer.

"We held this workshop to begin a dialogue among the scientific community, women's groups and policy-makers. As scientists, we wanted to learn what questions and concerns there were about family planning and to offer current, scientifically-based information on both the known benefits and risks of various contraceptive methods.

"Family planning clients cannot make good decisions without good information. This workshop was an attempt to provide some very

basic information about contraception."

FHI staff organized the workshop within 48 hours. A distinguished panel of international experts agreed to speak, and representatives from several family planning organizations were asked to attend, to serve as "resource" people and to help answer audience questions.

Dr. Felicia Stewart, deputy assistant secretary for population affairs at the U.S. Department of Health and Human Services, spoke on barrier method contraceptives, including the new polyurethane condom for women and research on a plastic condom for men.

Dr. Luella Klein, a professor of obstetrics and gynecology at Emory University, Atlanta in the United States and a member of FHI's Board of Directors, discussed intrauterine devices, injectable contraceptives and subdermal implants.

Dr. Pouri Bhiwandi, a native of India now practicing obstetrics and gynecology in the United States, spoke on oral contraceptives and on male and female sterilization. Dr. Bhiwandi is a former medical director at FHI.

Natural family planning (NFP) methods, including periodic abstinence, the Lactational Amenorrhea Method (LAM), and the Billings ovulation method, were the focus of the talk by Dr. Nancy Williamson, FHI's women's studies director and a scientist who has studied NFP.

Resource people in the audience included Dr. Douglas Huber of Pathfinder International, Dr. Claude Aguilhaume of the Population Council, Dr. Gordon Perkin of the Program for Appropriate Technology in Health (PATH), and Hugo Hoogenboom of AVSC International.

Examples of the myths addressed by panelists at this and other FHI workshops include the following:

- **Myth:** Male condoms have such high failure rates, their use actually increases the spread of sexually transmitted diseases.

- **Fact:** Condom breakage and slippage rates range from none to 12 percent, according to several international studies. An FHI study showed a breakage and slippage rate of 8.7 percent but found that 16 of the 170 couples studied were responsible for half the condom failures. The four factors associated with condom failure were: no recent experience with condoms; previous condom breakage; not living with sexual partner; and 12 or fewer years of schooling. Education about how to properly use condoms can help prevent failure of this method.

- **Myth:** Natural family planning is not effective.

- **Fact:** NFP, which takes advantage of a woman's naturally occurring monthly cycles of fertility and infertility, can be an effective means of preventing or spacing pregnancy. Couples must be educated about its use and must be able to incorporate the method into their lifestyle. Studies have shown failure rates for NFP methods about 20 percent



DONNA DECESARE

JOANN LEWIS, FHI SENIOR VICE PRESIDENT FOR REPRODUCTIVE HEALTH, LEADS A PANEL OF FAMILY PLANNING EXPERTS AT THE NGO FORUM.

To meet the need for basic information on contraception and to correct misinformation, FHI organized an impromptu workshop on contraceptive facts and fallacies. This workshop, which featured a panel of experts to answer questions from the audience, was in addition to three planned FHI workshops on reproductive health issues.

during a year of typical use. "These methods are very unforgiving of human error," said Dr. Williamson of FHI. LAM, which uses return of menses and breastfeeding patterns to gauge a woman's return to fertility, can be 98 percent effective when used correctly.

• **Myth:** Oral contraceptives cause cancer.

**Fact:** The question of whether combined oral contraceptives — those that include both the hormones estrogen and progestin — increase a woman's risk of breast cancer is unresolved. Studies on this issue continue. However, oral contraceptives actually reduce a woman's risk of ovarian and endometrial cancers. Although a causal relationship between pill use and cervical cancer has not been established, the concern that a link may exist makes it advisable that pill users receive regular cytologic screening (Pap smears). A link between COCs and liver cancer has been found in a developed country, but was not confirmed by WHO studies in several developing countries. The type of liver cancer (hepatocellular carcinoma), while very rare in the developed world, is common in the developing world where its most important risk factor is hepatitis B infection.

• **Myth:** Spermicides increase a woman's chances of contracting AIDS and STDs.



RICHARD LORD

A HEALTH WORKER IN AWENDO, KENYA GIVES HER CLIENT INFORMATION ABOUT ORAL CONTRACEPTIVES AND SPERMICIDES.

**Fact:** Studies among different populations consistently using different spermicide methods show that spermicide use reduces the risk of contracting bacterial STDs, such as gonorrhea and chlamydia.

Scientific research has not yet determined whether spermicides protect against viral STDs, such as HIV. "We can't say at this point whether spermicides are a good protection against HIV," said Dr. Stewart. An FHI study in Cameroon found that women with multiple sexual partners who used spermicides were consistently less likely to contract HIV than a comparison group of women who used spermicides intermittently. However, a randomized study in Nairobi showed that prostitutes who used a spermicidal sponge were more likely to be infected with the HIV virus than women not using spermicides. Scientists speculate that high doses of spermicides (use several times a day) may irritate the vagina, which make transmission of HIV more likely. Women who use spermicides less often report fewer cases of irritation.

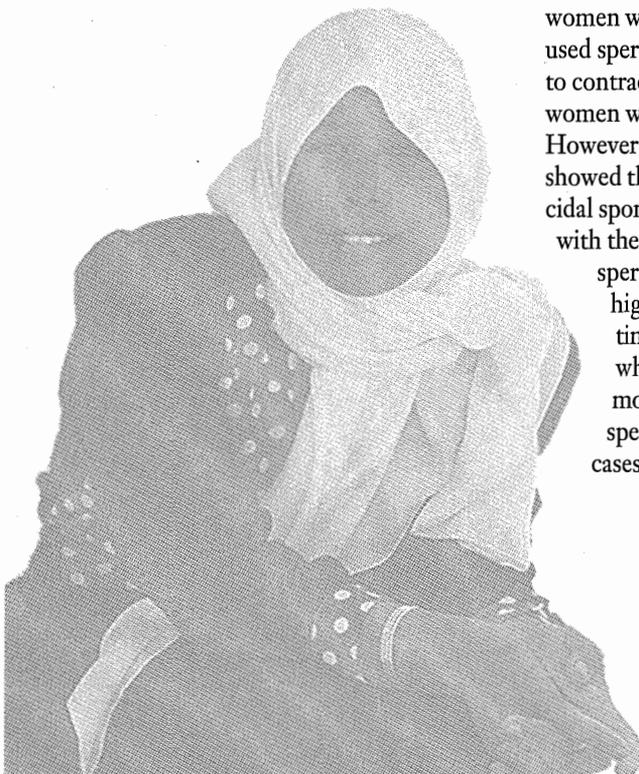
In considering women's and men's contraceptive needs, no one method of family planning should be viewed as the "best," panelists said.

"There are advantages and disadvantages with all methods," said Lewis of FHI. "What is important is to provide a range of family planning options for clients and clear information to enable them to choose the options that are best for them."

FHI's presentations at the NGO Forum gave its researchers an opportunity to inform policy-makers and women's advocates about family planning methods, FHI's work in AIDS prevention and other areas of women's reproductive health. Also, the NGO Forum was an opportunity for policy-makers and women's advocates to share their concerns for future directions of research on contraception, family planning and AIDS.

"The panel discussions were a learning opportunity for those of us who work at FHI," says Lewis. "We came to the NGO Forum wanting an exchange of ideas, wanting to hear the concerns of other organizations and wanting to offer FHI's research as a tool for policy-makers and women's advocates involved in family planning and AIDS. We hope our roles as both educators and learners will continue well beyond Cairo."

— Barbara Barnett



# Resources

## MONOGRAPH ON BARRIER METHODS

Family Health International has published *Modern Barrier Methods: Effective Contraception and Disease Prevention*, a book for health-care providers and family planning program managers that discusses the safety, effectiveness and acceptability of barrier



methods. Written by two FHI researchers, the 64-page book is an easy-to-read, comprehensive guide that examines scientific research findings and explores programmatic issues related to barrier use. It is available at no cost upon written request from developing country agencies and individuals, and costs U.S. \$13.95 for others. For a copy of the book, write: Publications Coordinator, Family Health International, P.O. Box 13950, Research Triangle Park, NC 27709, USA.

## CDC'S HIV/AIDS RESOURCES

The U.S. Centers for Disease Control National AIDS Clearinghouse publishes a quarterly update of their *List of HIV/AIDS Materials*, an inventory of available information on HIV. The publication lists brochures, posters, displays, reports, videotapes, and documents on computer dis-

ettes. Some items are free. To receive a copy, write: CDC National AIDS Clearinghouse, Publications Ordering Department, P.O. Box 6003, Rockville, MD 20849-6003, USA, or telephone (301) 217-0023, or fax (301) 251-5343.

## STRENGTHENING PROVIDER PRACTICES

Publications are available summarizing the proceedings of two FHI regional meetings on how provider practices can improve access to contraception. Publications on a meeting in Manila, the Philippines (in English) and Panama City, Panama (in Spanish) examine the effect medical barriers have on quality of care and review international and regional experiences with medical barriers to contraception. The proceedings of the meeting in Panama, *Cómo mejorar las prácticas de los proveedores: aspectos notables del taller regional latinoamericano: reducción de barreras médicas en anticoncepción*,



and the proceedings of the Manila meeting, *Improving Provider Practices: Highlights of the Workshop "Reduction of Medical Barriers to Contraception,"* are available at no cost from: Publications Coordinator, Family Health International, P.O. Box 13950, Research Triangle Park, NC 27709, USA.

## PACT, INC. AIDS RESOURCES GUIDE

Directories, newsletters, guides, and public education materials related to AIDS, as well as health promotion resource centers for AIDS worldwide, are listed in *AIDS, an International Resource Guide*. The guide, published by PACT, Inc., is designed to assist professionals and community workers fighting AIDS in the developing world. The 60-page guide briefly describes the resources and gives contact information for obtaining them. Most materials listed are free. To obtain a copy of the guide, write: PACT, Inc., Communications Development Service, 777 United Nations Plaza, New York, NY 10017, USA, or telephone (212) 697-6222, or fax (212) 692-9748.

## PUBLICATIONS ON DEMOGRAPHY

Population Reference Bureau has published several booklets on demography in the developing world. *Seeking Common Ground: Demographic Goals and Individual Choice* addresses the worldwide evolution of population concerns, the unmet need for family planning, satisfying unmet need rather than achieving population targets, and the health benefits of addressing unmet need.

Two chartbooks deal with demographic change in regions of the developing world. *Paths to Demographic Change in the Near East and North Africa* and *A Demographic Portrait of South and Southeast Asia* address particular concerns in each region related to fertility patterns, family planning, childbearing preferences, knowledge of family planning

and unmet need, education, maternal health, and child health and mortality.

To receive a copy of any booklet, write: International Programs, Population Reference Bureau, 1875 Connecticut Avenue, NW, Suite 520, Washington, DC 20009, USA.

## WOMEN WRITE ABOUT REPRODUCTIVE HEALTH

*Conveying Concerns: Women Write on Reproductive Health* reflects the conviction that development programs are most effective, appropriate and comprehensive when they include



the ideas and participation of women. The booklet conveys a range of women's concerns on the subject of reproductive health, including demographic change, discrimination against women, family planning, maternal mortality, abortion, AIDS, adolescents, and women's rights. The publication is a compilation of articles by senior editors of women's magazines and newspapers in seven developing countries. For a copy, write: International Programs, Population Reference Bureau, 1875 Connecticut Avenue, NW, Suite 520, Washington, DC 20009, USA.