

# Network

FAMILY HEALTH INTERNATIONAL, VOL. 19 NO. 4, SUMMER 1999



New Contraceptive Users

# News Briefs

## AFFORDABLE DRUG REDUCES HIV RISKS

Scientists in Uganda and the United States have found a simple and relatively inexpensive drug treatment to reduce the risk of HIV transmission from infected mothers to their infants during birth, a strategy that promises to save thousands of infant lives throughout the developing world.

The approach uses a single oral dose of the antiviral drug nevirapine given to the infected mother during labor and a dose to her baby within three days of birth. The treatment reduces the transmission rate of HIV by nearly half compared to a similar short course using AZT. A longer course of AZT than used in the study is considered the standard of care in the developed world, but is unfeasible in resource-poor countries. The nevirapine regimen costs about U.S. \$4. By contrast, a short AZT regimen costs about U.S. \$270. A longer AZT therapy over five months of pregnancy can cost about U.S. \$1,000.

"This research provides real hope that we may be able to protect many of Africa's next generation from the ravages of AIDS," says Dr. Crispus Kiyonga, Ugandan health minister. Scientists at Makerere University in Kampala and Johns Hopkins University in the United States conducted the study, with data analysis at the U.S.-based Fred Hutchinson Cancer Research Center and University of Washington. FHI managed the study, which was

financed by the U.S. National Institute of Allergy and Infectious Diseases (NIAID).

The study involved 618 HIV-infected mothers who were given either the nevirapine treatment or the short AZT regimen. At three to four months of age, 13 percent of infants who received nevirapine were infected with HIV, compared with 25 percent of those in the AZT group. Without treatment, about 30 percent of infants born to HIV-positive mothers get their mother's infection. Widespread use of the nevirapine strategy in Africa, where the majority of HIV-infected babies are born, could prevent the infection and premature death of more than 300,000 infants annually.

A treatment initiated during labor is important for developing countries, since many women do not receive medical care prior to delivery. Researchers announced the findings in July 1999, and will continue following the infants until 18 months of age to determine long-range effectiveness.

## CONTRACEPTIVE PATCH TESTED

An adhesive patch that delivers contraceptive drugs through the skin is being developed by Johnson & Johnson, a U.S.-based company that manufactures birth control pills and other pharmaceutical products.

The company announced in July 1999 that it is in the final stages of testing the patch on hundreds of women and plans to seek approval from the U.S. Food and

Drug Administration (FDA) in the year 2000. A review by FDA is expected to take at least a year.

The patch, about the size of a large coin, can be worn on the arm, abdomen or buttocks, and uses the same hormones as the pill. It is expected to be as effective as oral contraceptives, the company says, but can reduce such side effects as nausea and vomiting. The patch is replaced weekly and may be more convenient for women to use than the daily pill, which some women forget to take.

"For women who have difficulty remembering to take birth control pills, this is an excellent method," says Gloria Feldt, president of the Planned Parenthood Federation of America.

## JAPAN APPROVES ORAL CONTRACEPTIVES

After years of deliberation, the Japanese Health Ministry has approved the use of oral contraceptives.

Japan was the only industrialized country to have banned use of the pill for contraception (the pills in higher doses had been allowed for treating menstrual disorders or other medical conditions). Among concerns delaying approval of the contraceptive pills was fear that their use would promote promiscuity, lead to high rates of sexually transmitted diseases, or cause estrogen-related harm to the environment or personal health. In fact, adverse health effects from the pills are rare among the more than 300 million women worldwide who have used them. Japanese couples have long relied on condoms for contraception.

## ONE-ROD IMPLANT TO BE OFFERED IN EUROPE

European sales of a single-rod contraceptive implant called Implanon are expected to begin this fall in six countries, according to the company that developed the device.

Intended for three years of use, Implanon is currently available in Indonesia, says NV Organon OSS of the Netherlands. The device is scheduled to be offered this fall in the United Kingdom, the Netherlands, Austria, Denmark, Finland and Switzerland.

Overall, studies involving 2,362 women using Implanon have been conducted, including a recently published four-year study involving 200 women in Indonesia, says Dr. Tjeerd Korver, coauthor of the recent study and a researcher at Organon.

Research shows that the one-rod implant is safe, effective and well-accepted, he says, and is easier to remove than the six-capsule Norplant implant. Average removal time of two minutes for Implanon compares with about eight minutes for experienced providers to remove the six Norplant rods. "Insertion and removal procedures appear to be rapid and uncomplicated, from the perspective of the provider as well as the user," says Dr. Korver.

The recent study, reported in the March 1999 issue of *Contraception*, found no pregnancies among Indonesian women using Implanon. Norplant is considered 99 percent effective against pregnancy. The proportion of women using Implanon who reported menstrual bleeding irregularities was similar to that of Norplant implants.

**Network** is published quarterly in English, Spanish and French by Family Health International and is distributed without charge. Periodicals postage is paid at Durham, NC and additional mailing offices. POSTMASTER: Send requests, queries and address corrections to:

**Network**  
Family Health International  
P.O. Box 13950  
Research Triangle Park, NC 27709 USA

To obtain a free subscription, please write to the Publications Coordinator at the above address.

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Family Health International is a nonprofit research and technical assistance organization dedicated to contraceptive development, family planning, reproductive health and AIDS prevention around the world.

**Network** is supported in part by the U.S. Agency for International Development. The contents do not necessarily reflect FHI or USAID policy.

 ISSN 0270-3637  
USPS 696-610

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FAMILY HEALTH INTERNATIONAL, VOL. 19 No. 4, SUMMER 1999

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*Many new contraceptive users are couples who already have children. The cover photograph, by Crispin Hughes of Panos Pictures, shows a typical family in Kenya.*





# First-time Users Have Diverse Needs

Many people delay use because of poor access to services, fear of side effects or family opposition.

**F**irst-time contraceptive users are a diverse group. Some are adolescents who initiate contraceptive use months after first intercourse, risking unplanned pregnancy or sexually transmitted disease. Some are adult women and men who do not want to use contraception until after the birth of a child and fertility is proven. Others are older women and men who do not begin contraceptive use until they have reached their desired family size or are ready to end childbearing.

Lack of access to services, lack of information about available methods and how they work, or fears about side effects can discourage women and men from starting to use contraceptives. In addition, cultural norms — such as preference for a large family, the value of sons over daughters, status gained through motherhood, and male control over female behavior — can affect contraceptive initiation.

Family planning workers should be aware of the multiple needs, concerns and experiences of first-time contraceptive users.

“For many women and men, contraceptive use is not part of a long-term life plan,” says Dr. Priscilla Ulin, an FHI researcher and director of the recently completed Women’s Studies Project. “Often contraceptive use is a reaction. It comes in response to a pregnancy scare, an unplanned pregnancy, an unwanted pregnancy, or too many pregnancies.

“There are many women who would like to use contraception but do not. They worry erroneously that contraception might make them sick or sterile, so they are afraid to risk that possibility before they have completed their family size. Sometimes new users are clandestine users, especially when they are the first in their community to make a decision that contradicts social and cultural norms.”

Health workers can help women and men understand the value of contraceptive use as a way to space, delay or end childbearing.

## OLDER WOMEN AND MEN

For some couples, the idea of planning a family is acceptable. However, they do not want to space or limit births until after their first pregnancy or until they have reached their desired family size.

In Zimbabwe, FHI’s Women’s Studies Project found a pattern in women’s reproductive lives. On average, first menstruation occurred at age 14, first sex at 18, marriage at 19, and first birth at age 20, according to a national sample of nearly 2,500 women. For the majority of women, first contraceptive use did not take place until after first birth. Only 11 percent of women reported that they used family planning at first sex, and the figure dropped to 9 percent at marriage. However, the proportion jumped to 58 percent after first birth.<sup>1</sup>

“It is extremely necessary to have a first child before a couple contracepts,” one woman explained. “Why would one practice family planning if one does not even have a

family? ... You will never know what contraception might do to a woman's system. It might make her sterile before they even have a child."<sup>2</sup>

Other studies in Africa and elsewhere have also shown that many couples believe first birth should precede contraceptive use. In Turkey, a survey of 918 married women ages 15 to 44 found that 73 percent did not begin contraceptive use until after first birth. Nearly half of those who did use a method chose withdrawal, fearing modern method side effects.<sup>3</sup> In Bangladesh, a survey of 128 couples found that one-third of the women and half the men said women should prove fertility before they use family planning. Traditional methods, such as abstinence, herbal preparations and withdrawal, were popular at the beginning of women's reproductive careers, especially during the interval between marriage and first birth.<sup>4</sup>

Older women seeking contraception for the first time at Asociación Probienestar de la Familia (PROFAMILIA) clinics in Colombia are likely to want the intrauterine device (IUD) or sterilization, says María Isabel Plata, executive director. Although it is their first clinic visit, it is often not their first attempt at contraceptive use. Many have tried condoms or pills, which they can get over-the-counter in their country. They are tired of using short-term methods or have experienced a pregnancy from using methods incorrectly.

In India, most new users are interested in permanent, not reversible, methods, says Dr. Nina Puri, president of the Family Planning Association of India (FPAI). "The concept of family planning in India has traditionally been accepted," Dr. Puri says. But many women start using contraception after having three or more children. "They really did not want to come in to space births, and they did not have enough information about temporary methods," she says.

India's National Family Health Survey of nearly 90,000 ever-married women of reproductive age found only 4 percent of women with no children were using family planning. The figure jumped to 19 percent for women with one child, to 46 percent for women with two children, and to more than 50 percent for women with three or more children.<sup>5</sup>

Historically, the Indian government has promoted male and female sterilization in its family planning programs. The emphasis is

changing, but for many couples sterilization is the first and only method of contraception they use. In the national survey, sterilization was the most popular method, with few women knowing about or using reversible methods.

Sterilization as a first contraceptive is prevalent elsewhere as well. Studies in 19 countries, conducted by Demographic and Health Surveys, found that one-third of sterilized women in Indonesia and two-thirds in Sri Lanka had not used a modern contraceptive method before being sterilized. Fifty-three percent of women in Kenya and 36 percent in Botswana said they had not used a modern method before sterilization. In Latin America and the Caribbean, the percentage of women who had not used a modern method before sterilization ranged from 17 percent in Trinidad and Tobago to 54 percent in Bolivia.<sup>6</sup>

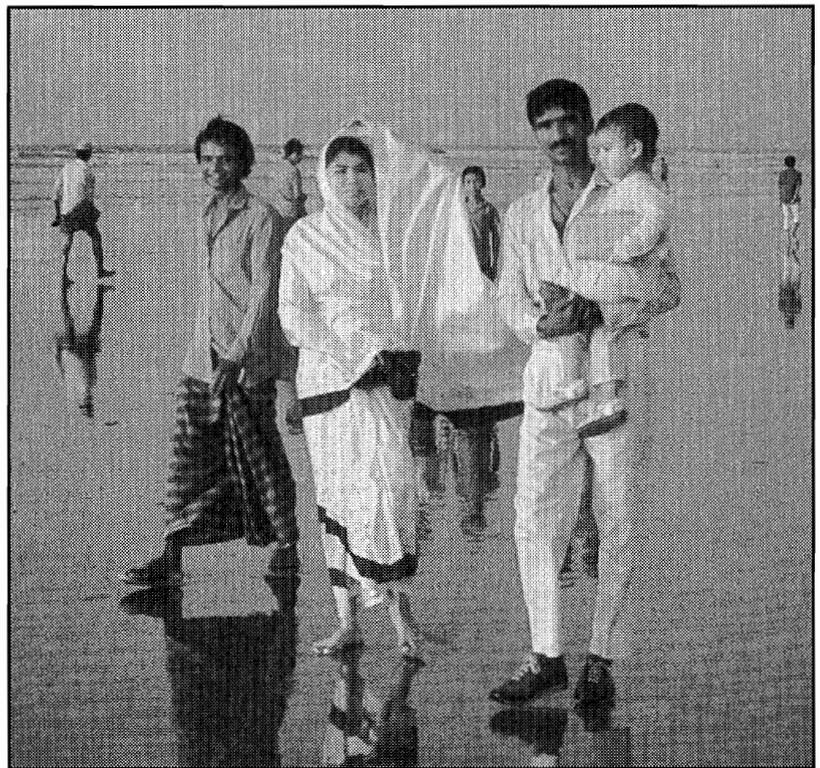
An FHI study in Nepal surveyed 817 sterilized women and found that, for 81 percent, sterilization was their first contraceptive method, although 93 percent were aware of at least one temporary modern method that could be used for spacing.<sup>7</sup>

Nearly 40 percent of women who were sterilized had five or more children, and nearly two-thirds of women were under age 29. Researchers outlined a reproductive pattern that includes marriage at an early age (47 percent of women are married by age 17), first birth by age 21, and an average of 2.6 births before age 30, at which time the demand for family planning increases. A separate study found that women and men associated family planning with "stopping children." They were not familiar with the concept of child spacing.<sup>8</sup>

For older women and men, the reasons for non-use of contraception are varied. They include lack of access to methods and information, fear of partner disapproval, fear of side effects, fear of loss of fertility and preference for sons.

For health providers who work with older first-time users, an important strategy is to educate women and men that they do have a choice. "If you are very poor, you cannot plan anything — going to school, your work, improving your home — you do not even have a home," says Plata of PROFAMILIA. "The idea of planning, creating a future, is out of that person's universe."

TRYGVE BOLSTAD/PANOS PICTURES



A VARIETY OF PEOPLE ENJOY A DAY AT THE BEACH IN BANGLADESH. FIRST-TIME CONTRACEPTIVE USERS ARE A DIVERSE GROUP THAT INCLUDES YOUNG ADULTS BECOMING SEXUALLY ACTIVE AS WELL AS OLDER COUPLES WHO HAVE ACHIEVED THEIR DESIRED FAMILY SIZE.

Contraceptives can be used not only to end childbearing, but to delay or space children to improve maternal and infant health. Health workers can explain to couples that they can choose between permanent or reversible methods. And they should explain that side effects can be managed or minimized.

In addition, health workers can educate the family and the community — not just the contraceptive user. “We go to women with their first child and talk about spacing. We talk to men, and we talk to the family as a whole,” says Dr. Puri of India. “We have found that programs have to address specific audiences. The way we address issues has to be attuned to sensitivities of the communities where we work.”

FPAI has 22 clinics that provide some type of services to men. Condom use has increased, and concern about AIDS has prompted men to take a more active interest in their own reproductive health and the health of their wives. Dr. Puri recommends that family planning programs have special hours for men, including clinic times that do not conflict with men’s work hours.

#### SECRET USE

Without husband approval or community support, contraceptive use for many women is a difficult and risky decision that can lead to abandonment, violence, ostracism or divorce. Consequently, some women begin contraception secretly, without their husband’s knowledge.

“Providers should know whether a woman is coming with the concurrence of her husband or if she is coming in secret,” says Dr. Ulin of FHI. “In the case of clandestine users, providers need to assure the client of absolute confidentiality.”

A small study in Mali, conducted by FHI and the Centre d’Etudes et de Recherche sur la Population pour le Développement (CERPOD) as part of the Women’s Studies Project, found that about one-third of 55 first-time users had come to a family planning clinic without their husbands’ knowledge.<sup>9</sup> Seven of the 17 clandestine users said they were too shy or too afraid to discuss family planning with their husbands, and the

remainder had tried but encountered disapproval, including concern that family planning violated religious teachings.

More than half the clandestine users in the Mali study chose injectable contraceptives because they felt this method was easy to keep secret. However, many women who chose oral contraceptives said this was also a good option, since they could carefully hide pill packets.

The Population Council estimates that in countries where contraceptive prevalence is less than 10 percent, secret use of methods accounts for a substantial number of users. For example, in the urban Ndola district of Zambia, 7 percent of some 800 women

not cared for, no clothes, they move about aimlessly, no food, and start begging from the streets.”

A study in Uganda found that 15 percent of women who were using family planning did so without their husband’s knowledge, while in rural Kenya, 20 percent of women said they used family planning clandestinely.<sup>11</sup>

Family planning programs can help women using methods in secret by providing a range of contraceptive choices and by helping women manage side effects. As one study participant in Zambia explained, “She has to choose a method that has no side effects, because if she suffers ... the husband will be furious and tell her to count him out of that problem.” Men should also be encouraged to learn more about family planning.

#### ADOLESCENTS

Many young adults do not use contraception at first intercourse; contraceptive use may not begin until months later. There are numerous reasons why contraception is an afterthought. For example, many adolescents do not plan when to have sex, do not know where or how to obtain family planning, are simply too embarrassed to seek contraception or are denied methods by clinic staff or pharmacists. Others may not understand when the fertile time occurs in the woman’s menstrual cycle, think they are too young to get pregnant, or are afraid contraceptive use can damage fertility.

“It is scary to use pills or an injection regularly, especially at our ages,” one young woman from Zimbabwe explained to FHI researchers. “We are afraid the use of condoms might reduce our chances of getting pregnant when we get married.”<sup>12</sup>

In Jamaica, a 1997 national survey of young adults ages 15 to 24 found that the older adolescents were when they had first sex, the more likely they were to use contraception. Among those who had first sex when they were younger than 14, 41 percent of the girls and 17 percent of the boys said they used contraception. Among those who had first sex at ages 18 to 24, nearly two-thirds of the women and 53 percent of the

WOMEN WITH TWO OR MORE CHILDREN AT FIRST CONTRACEPTIVE USE (PERCENTAGE AMONG ALL WOMEN USING CONTRACEPTION)	
<b>ASIA</b>	
Bangladesh	52
India (Uttar Pradesh)	79
<b>AFRICA</b>	
Ghana	40
Tanzania	55
<b>LATIN AMERICA</b>	
Bolivia	45
Colombia	24
Dominican Republic	37

Source: Demographic and Health Surveys

interviewed said they were using family planning without their husband’s knowledge.<sup>10</sup> Conducted by the Population Council and the African Population Policy Research Center, the Zambian study found that reasons for covert use included husbands’ disapproval of contraception, husbands’ desire for many children, and difficulty between husband and wife in communicating about family planning. Women also said they started using family planning to improve the health and well-being of the children they already had. “You just observe what is happening at home,” one woman said. “If there is no support, you start a pill secretly. The children look miserable and



YOUNG ADULTS GATHER IN ETHIOPIA. SOME YOUNG ADULTS MAY NOT KNOW HOW TO OBTAIN FAMILY PLANNING SERVICES OR ARE TOO EMBARRASSED TO SEEK THEM.

men used contraception. A stable relationship, higher family income, and higher educational attainment also influenced contraceptive use at first sex.<sup>13</sup>

An FHI survey among Jamaican adolescents in their early teens (grades 7 and 8) found similar lack of contraceptive use at first sex. Slightly more than two-thirds of the 51 sexually active girls and less than one-third of the 251 sexually active boys reported using contraceptives at first intercourse. The most popular method was the condom. Young adults had mixed views on family planning, with a majority saying contraceptive use is responsible behavior but others saying it is for people with multiple partners. In focus group discussions, one boy said condom use would draw ridicule from peers, who would laugh and "call him a little boy." Another young man said he would use condoms because he "loves my life, you know" and "cannot bother with no AIDS thing."<sup>14</sup>

Similar trends have been observed in other countries. In Kenya, a study of 2,059 secondary school students found that only 25 percent of the boys and 28 percent of girls used contraception at first sex.<sup>15</sup> In

Mexico City, a study of more than 1,000 young adults, ages 10 to 25, also found low contraceptive use at first sex.<sup>16</sup>

In Colombia, family planning workers are trying to change the trend of adolescents initiating sexual activity without contraceptives, says Plata of PROFAMILIA. The majority of young clients come to PROFAMILIA clinics "because they are already sexually active and they are worried or have had a scare, and they come for a pregnancy test," she says.

To encourage young people to use contraception during first sexual activity, PROFAMILIA distributes contraceptive information and tries to make it easier for adolescents to obtain methods. The organization operates a telephone hotline, provides emergency contraception, and encourages young men to use contraception.

"With the young men, we talk about respect for the girl, self-esteem and sexuality," says Plata. "They become more open, less *machista*, more democratic, and they start to consider what she wants and also what he can do in the whole question of contraception. We start working with the idea of the responsibility of two."

— Barbara Barnett

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# Why Do People Change Methods?

Among reasons, some users change family planning goals, while others switch to avoid side effects.

Some individuals or couples select a contraceptive method and continue using it throughout their reproductive lives. Others will change methods several times.

There are many reasons why people switch methods. Their contraceptive needs may change over time. They may want greater effectiveness. Or, they may be dissatisfied with side effects, have problems getting a method, or have previously followed poor advice from clinic staff. Some may simply wish to experiment, if various contraceptive options are available.

Often, women and men first try methods that are easy to get or use, but may be less effective than other methods. Later, when they feel more urgency to limit their fertility, they tend to switch to more effective methods.

In Sri Lanka, 40 percent of some 300 users of reversible modern methods switched within two years to a more effective method, with switching mainly occurring as women approached their desired family size.<sup>1</sup>

In a retrospective survey of contraceptive use over four years among 715 rural Kenyan women of reproductive age, women tended to adopt long-term or permanent methods as they became older and had more children. Many were "casual" family planners at first. That is, they used a method to delay pregnancy and, if the method failed, they tended to view an unintended pregnancy simply as a matter of poor timing.

However, once women had had three or four children, unintended pregnancies were less acceptable and the women were more likely to adopt long-term or permanent methods.<sup>2</sup>

In Jordan, the rhythm method, withdrawal and the lactational amenorrhea method (LAM) were considered by married couples who participated in focus group discussions to be both safe and in keeping with Islamic religious principles. However, researchers noted that, while widely used, these methods were often used incorrectly, leading to failure. Changing to modern methods tended to occur only after one of these traditional methods had failed, several children were born, or the couple faced money problems. "We started by planning, using the rhythm method," recalled one urban woman. "After two children, we continued to use it, but it did not work. I had a third child, then had an intrauterine device (IUD) inserted."<sup>3</sup>

On the other hand, side effects associated with some modern methods may cause women to change to other methods, some of which may be less reliable.

In the Jordanian study, side effects from IUDs and oral contraceptives were identified as the main reason for switching from modern to traditional family planning. "Sometimes we used pills, sometimes the rhythm method," said an urban man. "When my wife suffered the side effects of the pill, she stopped using them and shifted

to the rhythm method for three, four, five or six months. I used withdrawal when I feared there had been a mistake in our counting.”

High discontinuation rates for the IUD and the pill, largely due to fear of adverse health effects, were also observed in a survey involving some 900 married Turkish women. Authors of the study noted that many couples seemed to resort to withdrawal in order to escape the perceived or actual side effects of modern methods.<sup>4</sup>

In an FHI study conducted in Indonesia in collaboration with the Population Studies Center, Gadjah Mada University, nearly a fifth of 720 contracepting women reported health problems with contraceptive use. Side effects usually led to method switching. For example, a rural 29-year-old mother of three told an interviewer that she originally used an IUD, but an infection that she believed was related to her IUD led her to begin using condoms instead, which are less effective. After a couple of months of condom use, this woman switched back to the IUD. Further problems with the IUD, however, caused her to use an injectable contraceptive, which she abandoned after three injections because it caused the side effect of spotting (intermenstrual bleeding). Finally, she switched to Norplant subdermal implants.<sup>5</sup>

A survey of 800 women from Lampung and South Sumatra, Indonesia, conducted by FHI in collaboration with Atma Jaya Catholic University, also revealed that many women changed contraceptive methods after experiencing side effects, particularly those associated with hormonal methods and the IUD.<sup>6</sup>

“The amount of method switching due to side effects among women in these two studies was surprising and underscores the importance of providers fully informing clients about possible effects,” says Dr. Karen Hardee, who was FHI’s monitor of the two Indonesian studies and is currently with The Futures Group International. “Some providers worry that if they fully inform clients about possible side effects, clients will not even begin using the methods. But a client who is ill-informed and experiences a side effect may discontinue the method out of fear, not realizing that the effect is normal and probably transient.”

Inappropriate medical advice or practices by clinic staff and periodic unavailability of some methods, supplies or services can also lead to switching. Inconvenience can be another reason. In an FHI study conducted in collaboration with Xavier University in the Philippines, only a fifth of some 900 current users of family planning and 350 past

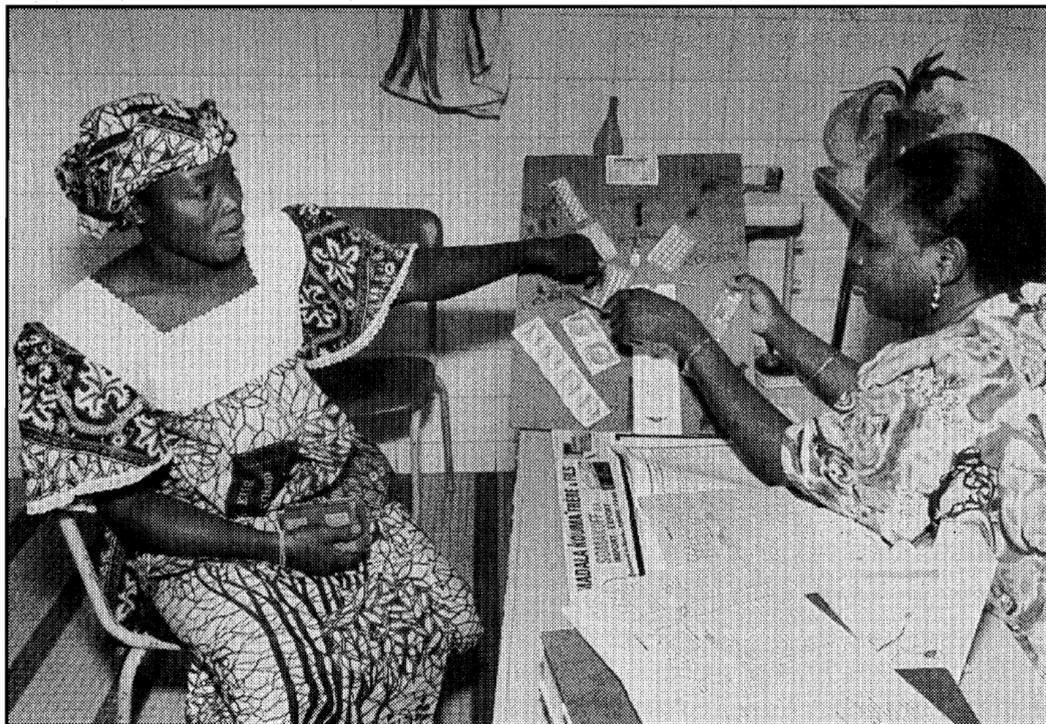
users had ever changed methods. However, when switching occurred, it was often associated with distant locations of clinics, limited clinic service or long waits at clinics.<sup>7</sup>

## RANGE OF OPTIONS

Research in developing countries has shown that offering a variety of modern methods and encouraging dissatisfied clients to try another method results in higher contraceptive continuation rates. However, greater awareness and availability of a wide range of methods also may result in more method switching. In Indonesia, the Demographic and Health Surveys program found that educated contraceptive users were more likely to change methods than uneducated users, and urban users were found to be more likely to switch than rural users. Researchers concluded that educated users were probably more aware of available methods, likely to find an alternative method, and willing to experiment until they found a method that suited them. Similarly, urban women may have had more access to contraceptive information, increasing their awareness of choices.<sup>8</sup>

“Efforts should be made to prevent unnecessary switching — for example, switching due to a lack of understanding about side effects,” says Dr. Hardee. “However, switching in itself is not a bad thing. Women need to be allowed to switch. In fact, when providers have denied women the right to switch provider-controlled methods, women have justifiably felt coerced. The result is that a safe and effective method can get a bad reputation.”

An FHI study in Senegal of women’s experience with Norplant removal showed that women who wished to have implants removed commonly complained that they were forced to return to the clinic many times for counseling and treatment before their request was granted.<sup>9</sup> “Because a Norplant client must rely upon a trained provider to remove the implants, guaranteed access to removal upon the woman’s



RESEARCH SHOWS THAT OFFERING A VARIETY OF METHODS WITH ADEQUATE COUNSELING RESULTS IN HIGHER CONTRACEPTIVE CONTINUATION RATES. A WOMAN IN BAMAKO, MALI, LEARNS ABOUT VARIOUS METHODS DURING COUNSELING AT A CLINIC.



THE IDEAL METHOD FOR MANY YOUNG ADULTS IS THE CONDOM, SINCE IT IS EASY TO OBTAIN AND CAN BE HIGHLY EFFECTIVE IN PREVENTING BOTH PREGNANCY AND DISEASE. A CUSTOMER CONSIDERS CONDOM BRANDS AT A SMALL STORE IN MANILA, THE PHILIPPINES.

request is essential if Norplant is to be a method that expands reproductive choices, instead of curtailing women's freedom of choice," says Elizabeth Tolley of FHI, who coauthored the study. "Since requests for removal are usually due to an intolerance of side effects or a desire to get pregnant, they may be kept to a minimum if potential clients are well counseled about side effects and do not intend to have more children within five years of accepting Norplant."

Encouraging couples who are dissatisfied with a modern method to change to a traditional family planning method can be a good choice as long as both partners are determined to use the traditional method correctly and consistently. For example, a couple interviewed in a study conducted in the Philippines reported successfully using the calendar rhythm method for a total of 10 years. For the four years following the birth of their first child, they rigorously kept track of the woman's menstrual cycle and abstained from intercourse during fertile periods. But the husband wanted a break from this regimen and his wife switched to the pill. After three months, she developed a pill-related rash, abandoned the method, and became pregnant again. After the birth of this child, the couple resumed the calendar rhythm method, using it successfully for years.<sup>10</sup>

### A USER'S CHOICE

To discourage frequent method switching, providers should give clients the method they ask for as long as it is medically appropriate. There is a strong association between granting a woman's choice of a method, especially when her partner agrees, and her sustained use of it.<sup>11</sup> Clinic counselors should provide full information about the chosen method, thoroughly addressing the problems and side effects of the method before use begins.

Providers should also be able to explain fully the correct use of periodic abstinence, withdrawal or LAM. A couple may prefer such methods for many reasons, including religious beliefs, but may not understand how to use the methods effectively. Using traditional methods successfully requires an understanding of a woman's fertile cycle, for example. An unintended pregnancy may result in a couple feeling forced to change to a more effective modern method, although they believe its use is inappropriate.

The first clinic visit can affect contraceptive behavior. This was illustrated in a U.S. study in which nearly half of some 200 diaphragm users and two-thirds of some 325 oral contraceptive users had switched from these methods only five months after beginning to use them. Women who switched were more likely to have had inaccurate expectations about the methods and a poor

experience during their first clinic visit.<sup>12</sup> Among some 800 acceptors of the progestin-only injectable depot-medroxyprogesterone acetate (DMPA) in the Philippines, those women who were told they might experience side effects were more than three times as likely to continue using the method as those who had not received such counseling. Those who felt they had been treated in a caring and polite manner were 10 times as likely to continue using DMPA as those treated discourteously.<sup>13</sup>

If a client plans to discontinue a method and begin using another, the provider should urge her to do so immediately. Otherwise, she risks an unintended pregnancy. An analysis of contraceptive use by 1,000 Peruvian women, for example,

indicated that those who stopped using a method without starting another method were likely to become pregnant before either returning to the abandoned method or switching to another.<sup>14</sup>

Providers recommending that a client change methods because of a medical condition should be sure their concern is justified. The World Health Organization's (WHO) medical eligibility criteria for safe use of contraceptives can help them do so.<sup>15</sup>

If a client wishes to switch to another method because of side effects, providers should consider better alternatives. For example, if a woman likes the highly effective, progestin-only injectable DMPA but wishes to discontinue the method because of irregular bleeding, a provider might suggest an equally effective combined injectable, such as Cyclofem or Mesigyna, that would produce more regular menstrual bleeding.

Providers should not forget the male partners of women clients. Men can play a significant role in contraceptive method switching by discouraging use of particular methods. In the Philippines, DMPA acceptors whose husbands were opposed to the method were twice as likely to discontinue the method as women who had supportive husbands.<sup>16</sup>

Men may oppose the use of condoms, believing that the method reduces sexual sensation. Or, they may hold misconceptions about a method's mechanism of action or health effects. Other men may discourage their partners' use of a method if they think it can affect a woman's sex drive or physical appearance.

Although emergency contraception should not be used as a routine contraceptive, its use may prompt couples to begin or switch to a reliable, long-term method. Nearly two-thirds of 119 U.S. women who sought and used emergency contraceptive pills cited condom failure as the reason for using emergency contraception. In a follow-up survey conducted two to three weeks later, over half reported that they intended to change or had already changed their contraceptive methods, most to hormonal methods.<sup>17</sup>

Providing fertility control counseling to some 450 Irish female students who visited a university health center for emergency contraception was found to result in many students adopting more reliable contraceptive methods. At follow-up one to 36 months after the initial visit, 42 percent of the women had changed to a more reliable method than the one they had been using at the time they sought emergency contraception.<sup>18</sup>

Data about contraceptive switching among adolescents are limited. However, "adolescents tend to use easily obtainable, short-term, barrier methods, such as condoms, if they use any contraception at all," says Dr. Cindy Waszak, an FHI principal research scientist who has evaluated adolescent programs in the United States, Jamaica, Nepal and Africa. "A pregnancy scare often prompts adolescents either to initiate use of a method or to switch to a more reliable method. However, switching may be more difficult for adolescents than for adults. Adolescents are often reluctant to approach a family planning clinic because they are unfamiliar with the medical system and fear stigmatization for being sexually active."

Thus, it is important that family planning workers treat adolescents with respect. Counseling about side effects is essential because youth are more likely than adults to abandon a method if they are dissatisfied.

In many cases, the ideal contraceptive method for an adolescent is the condom. When used correctly and consistently, the condom is highly effective in preventing both pregnancy and sexually transmitted diseases. Counseling can help young, inexperienced people to use condoms correctly, as well as to negotiate condom use with partners.

Adolescents' sexual activity tends to be irregular and often unplanned, so the condom is a practical method that is often easy to obtain. Adolescents also face greater risks of infection from sexually transmitted diseases because they change partners more often than older adults. Also, younger women are more vulnerable than older women to infections such as chlamydia because of different anatomical and physiological characteristics of the cervix due to age.

— Kim Best

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# Social Contacts Influence Method Use

Friends, family and others spread family planning information and affect decisions.

**E**veryday conversations within various social groups can play an important role in a person's decision to begin contraception. Because of this, family planning programs can work with social groups to improve their services.

Family, friends and neighbors are examples of typical social networks. Others include women's groups; political, church or youth associations; mutual aid and credit groups; and marketing associations.

Some experts believe communication through these social networks can influence decisions to initiate contraception as much as media campaigns or information provided directly to clients by family planning programs.

"For the most part, social networks have been ignored when family planning programs are implemented," says Dr. Thomas Valente, who has conducted extensive research on social networks. "But it is wise to look at them more closely because they are an important force driving human behavior."

Many individuals feel uncertain about the health, social and economic consequences of using modern contraceptives. This uncertainty often leads people to discuss matters with their peers, to seek more information or just to be reassured about decisions to begin using contraception, says Dr. Valente, an associate professor at Johns Hopkins University, Baltimore, MD, USA.

"It is just human nature to be cautious," he says. "People do not necessarily trust what they are told is the contraceptive experience of people who may well be from

distant countries. People tend to turn to others like themselves for information and advice." Targeting key individuals within social networks — opinion leaders, men and couples, for example — can help family planning programs achieve reproductive health goals, he says.

## SOCIAL LEARNING

Social networks can have an impact on contraceptive use in two ways: by spreading information and by influencing behavior.

The information that people need and seek, especially in settings with low contraceptive prevalence, includes contraceptive efficacy, how and where to obtain methods, and side effects of modern contraceptive use. Many surveys indicate that women worldwide are concerned about side effects.

Learning through informal conversations can also involve exchanges of information about the advantages and disadvantages of fewer children. Having fewer children can promote family well-being in many ways. Smaller families can mean better food, clothing, shelter and care for each family member. Proper spacing of births improves the health of both mother and child.

A study in rural Kenya found that about three-fourths of 866 women questioned in a household survey had talked to at least one person about family planning, and many talked to more than one person. Approximately 95 percent of these family planning

conversations involved other women, especially a sister-in-law or co-wife, friend or sister.<sup>1</sup>

In focus group discussions and interviews, women in this study said that the decision to start birth control, especially a modern method, is part of a process. "Information obtained from family planning professionals is weighed against discussions with other less socially distant women about their experiences, concerns about side effects, and relations with those (husband and mother-in-law) who have power over a woman's life," says Dr. Susan Cotts Watkins, a sociology professor at the University of Pennsylvania, Philadelphia, PA, USA, and coauthor of the study.

In Bolivia, a media campaign to promote family planning and reproductive health increased awareness and detailed knowledge of contraceptive methods. However, exposure to personal networks was associated not only with increased awareness and knowledge of methods, but also with attitudes toward, intention to practice, interpersonal communication about, and current use of contraception.<sup>2</sup>

Social influence can be exerted by individuals who wield power over others and by pressures to conform to social norms. Social influence may constrain use of contraception. Husbands or kin may forbid contraception, or community norms may threaten ostracism of a woman who uses birth control.

In an FHI study conducted in West Java and North Sumatra, Indonesia, in collaboration with researchers at the University of Indonesia, women said husbands were regarded as the head of the household, and few women used contraception without their husband's knowledge. For some women, contraceptive use was not an option if husbands did not approve. Explaining why she did not use contraception, a woman from North Sumatra said, "My husband does not permit me to use contraception. I am not brave enough, so I follow his advice. We have many children already."<sup>3</sup>

Other women in such a situation may resort to using contraception secretly, risking abuse, divorce or abandonment if their husbands become aware of this use.



EVERYDAY CONVERSATIONS WITHIN A PERSON'S SOCIAL GROUPS CAN PLAY AN IMPORTANT ROLE IN DECISIONS TO BEGIN CONTRACEPTION. WOMEN PREPARE PINEAPPLES AT A FOOD COOPERATIVE IN BOLIVIA.

In a Zimbabwean study conducted by FHI in collaboration with the Institute for Development Studies, University of Zimbabwe, most married men and mothers-in-law wanted their wives or daughters-in-law to bear many children to extend the family lineage. Most opposed the use of contraception until at least one or two children had been born. Many mothers-in-law favored contraception only as a means to space pregnancies or to prevent further pregnancies once there were numerous children.<sup>4</sup>

Another social pressure that limits contraceptive use is the view that adolescents should not be sexually active. In many areas of the world, sexual activity is taboo for young, unmarried women. This social norm limits access to some methods for sexually active adolescents, since contraceptive use implies sexual activity. In cultures that allow polygamy, this practice is another norm that may discourage contraceptive use. A woman in a polygamous marriage may want to have more children if her husband's other wives are doing so. Also, women throughout the world say that motherhood brings respect, another social pressure that discourages contraceptive use.

## POWERFUL ALLIES

Individuals who exert authority over a couple also have the potential to facilitate contraceptive use. Older sisters-in-law, for example, are powerful allies for new contraceptive users, according to a study conducted by FHI in collaboration with the Centre d'Etudes et Recherche sur la Population pour le Développement in Mali. In the study of new users, sisters-in-law older than the wife shared their own family planning experiences, often encouraged use, and tended to be advocates for wives whose husbands disapproved of family planning. "She asked me to speak about it first to my husband and, if he refused, to talk to her and she would call him to make him understand," said one new user about her sister-in-law. Said another: "My sister-in-law intervened because of my son and then the twins that I had. She asked me to use family planning. She told me not to stop, to continue with it."<sup>5</sup>

In Cameroon, a 1993 survey of some 500 women belonging to social associations found that women were more likely to use contraception when they were encouraged by group members, or if members used the method themselves. The likelihood of having ever used a contraceptive method was eight times greater for a woman who

thought members of her group used contraception, and it was 17 times greater for a woman who was encouraged by friends to use contraception. The associations, which range from loose affiliations of friends to formal political and economic organizations, comprised women whom survey respondents knew well and with whom they often talked.<sup>6</sup>

Another study in Cameroon, featuring focus group discussions with 94 women who belong to associations, found that many had tried modern methods, including the pill, intrauterine device, injections, male or female sterilization and Norplant, as well as barrier methods (condoms and spermicides) and traditional family planning (periodic abstinence). Information about family planning spread quickly in these groups. One notable exception was Moslem women, who said they needed their husband's permission before discussing family planning.<sup>7</sup>

In Kenya, women's clubs or groups are very popular. Some men also participate in social groups, mainly sports clubs. A study of more than 2,000 women and 2,000 men in Kenya, nearly half of whom belonged to clubs, found that membership was associated with greater awareness and approval of modern contraception. Female club members were also more likely to have ever used or to be currently using modern contraceptives than were women who did not belong to clubs.<sup>8</sup>

Furthermore, men and women club members in Kenya were more likely than nonmembers to discuss family planning with friends and acquaintances. Family planning discussions with both friends and acquaintances, rather than with just close friends, were associated with a much greater likelihood of using modern contraceptives. Women who had discussed family planning

with both types of individuals were eight times as likely to be currently using modern contraceptives. Men who had done so were three times as likely as were those who had limited family planning discussions with close friends only. Contact with casual acquaintances may offer better opportunities to consider new information or viewpoints, since close friends tend to share similar views.

Considerable interpersonal communication about contraception also takes place in Ghana. A study conducted in 1995 in



BERYL GOLDBERG

MEN PLAY SOCCER IN VERACRUZ, MEXICO. INFORMATION ABOUT REPRODUCTIVE HEALTH IS OFTEN EXCHANGED DURING SOCIAL GATHERINGS, INCLUDING MEN'S SPORTING EVENTS.

southern Ghana of some 300 men and 300 women found that individuals who had ever used modern contraception were much more likely to have talked about contraception with acquaintances than were non-users. Among men, ever-users had discussed modern contraception with two acquaintances on average, while never-users had such discussions with fewer than one person (0.8 person) on average.<sup>9</sup>

## USING SOCIAL NETWORKS

"We know that information about reproductive health is actively exchanged through social networks, and working with networks can help some family planning programs," says Dr. John Casterline, a researcher for the Ghana study and senior associate at the New York-based Population Council. "But the degree to which social networks affect contraceptive decision-making varies from setting to setting, and the magnitude of the effect is still unknown. Social scientists are continuing to try to measure this effect in order to determine whether and how scarce resources should be invested in working with social networks."

Meanwhile, family planning programs can take advantage of social networks to promote contraception and reproductive health in several ways.

First, "targeting opinion leaders, identified by the community itself, is a way to accelerate change," says Dr. Valente of Johns Hopkins University. "These opinion leaders tend to be conservative because they know others depend on their advice. They may not quickly promote change. But, if they eventually adopt an innovation such as modern contraception, that signals change for the community."

"In northern Ghana, which is highly patriarchal, men who are heads of compounds of 10 to 15 people are clearly gatekeepers for the introduction of information and new behaviors," adds Dr. Casterline. "It is essential to devote as much attention to the influential senior men as to the target population of women."

Targeting men for contraceptive education, in general, is a good way to increase male approval of contraception, he says. "We tend to neglect one of the most fundamental social networks — that of husband and wife. But a woman supported by a social

network of friends still may not use a contraceptive method if her husband does not approve."

In a pilot project of community-based distribution of contraception in Ghana, introduced by the Navrongo Health Research Centre in 1994, social support for family planning and a woman's belief — based on talking with her husband — that her husband supported her use of contraception were the two most important factors leading to her adoption of contraception. Conversation between husband and wife, and social support influenced contraceptive use more than literacy level, type of marriage or parity.<sup>10</sup>

When a woman walks in the door of a family planning clinic asking for a specific contraceptive, providers need to be aware that her social networks may be influencing her choice. They may be able to determine this by asking, "Why do you want to use this method?" If a social network is influencing a woman's choice, providers should not fail to offer her a variety of other methods, since no one method is ideal for everyone. The method that is most popular within a social group may not be the best choice for a couple. Yet, a couple may choose an inappropriate method if most of their acquaintances are using it.

Entire villages may encourage one contraceptive as the preferred method, perhaps based on the choices of the village's first contraceptive users. A 1984 census of 51 villages in Thailand, for example, revealed that each village tended to have a most popular contraceptive method, although the most popular method varied markedly among villages. Furthermore, in focus group interviews conducted in early 1991, village members were well aware of the most popular method in the village and could recall the first users of contraception in the village.<sup>11</sup>

"We believe people tended to adopt a method already being used extensively in their village not because they felt social pressure to do so, but because more was known about that method," says Dr. Barbara Entwisle, principal author of a report on the work in Thailand and a sociology professor at the University of North Carolina, Chapel Hill, NC, USA. "Even when individuals

were aware of side effects or failures experienced by earlier users, they preferred methods about which a great deal was known already."

However, the potential for shifts in method preference exists, adds Dr. Entwisle. In one of the focus group villages, a doctor who initially advised villagers to take the pill later made injectables available and encouraged their use. Injectables then became the most popular method in the village, illustrating how health workers can influence contraceptive use within social networks.

Providers of contraception also need to be more aware that clients commonly talk about reproductive health with members of their social networks both before and after they talk to providers. "Because these exchanges tend to be informal, rumors are all too easily spread about modern methods," says Dr. Casterline. "So there is a need for providers to correct misinformation circulating in the social networks and give accurate information about all available methods."

Clinic personnel should pay closer attention both to the information being spread in such networks, and the influence the networks exert. "Providers often dismiss social networks as spreading myths and rumors," says Dr. Watkins of her research experience in Kenya, "but some of the things network members say are, in fact, true. Furthermore, the networks provide something that clinic personnel cannot provide — information and opinions from people like themselves."

Providers can encourage satisfied contraceptive users to talk about their experiences with members of their social networks to accelerate the spread of information. "This would be particularly effective if providers were able to determine exactly which 'satisfied users' had the largest social networks," says Dr. Valente.

"At the very least, before a woman who has adopted a method walks out the door of a clinic, providers may want to find out who will support her choice. If she has no support in her social network, she is likely to discontinue use of the contraceptive."

— Kim Best

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# Unmet Need Affects Millions

One in four developing country married women wants to avoid pregnancy but does not use contraception.

Contraceptive use has increased markedly in recent years in most developing countries, as has the desire for smaller families. Millions of couples, however, want to delay or avoid pregnancy but are not using contraception.

Many factors contribute to this unmet need for contraception, including lack of knowledge about contraception, fear of side effects, opposition from husbands, ambiguous feelings about contraception, dissatisfaction with methods, and poor access to, or a limited range of, contraceptive choices.

In the developing world, about one in four married women who wants to avoid a pregnancy is not using contraception, according to unpublished data from Demographic and Health Surveys.<sup>1</sup> That equals about 150 million women in the developing world.

In terms of total population with unmet needs, Asian countries have the largest numbers. India by far has the

most, at 31 million couples. However, in terms of the percentage of married couples of reproductive age whose needs are unmet, sub-Saharan Africa leads the list. All of the six developing countries in which more than one-third of married women of reproductive age have unmet need are in sub-Saharan Africa (see table).<sup>2</sup>

Many others could also qualify as having unmet need for effective contraception, depending upon how surveys are designed and analyzed. These include sexually active unmarried women and men, users dissatisfied with their current method, those who use a method incorrectly, and those with a limited choice of methods.<sup>3</sup> While most studies focus exclusively on unmet need for married women, some research is being done to measure the unmet contraceptive need for other groups.

Regardless of how "unmet need" is defined, tens of millions of couples want to avoid pregnancy but are not able to use contraception. Recent studies offer a clearer picture of barriers to contraception and how they operate, and may lead to practical ways to attract new contraceptive users.

## MULTIPLE REASONS

Reasons for unmet need often overlap because of social and cultural factors that tend to influence sexual practices and reproductive health needs. Two extensive studies published in 1995 found that the major

TRYGVE BOLSTAD/PANOS PICTURES



A MARRIED COUPLE IN ZAMBIA.

reasons for unmet contraceptive need were lack of knowledge, health concerns and ambivalence about future childbearing. Other important reasons, depending on the country, included opposition by family members and side effects.<sup>4</sup> The studies only included responses from women.

"Many assume that if couples just had access to a method, they would use it, but this is a wrong assumption," says Dr. Nancy Yinger, who coordinated several recent studies on the causes of unmet need for contraception through the U.S.-based International Center for Research on Women (ICRW). "The causes and solutions are much more complicated than just lacking access. Even when contraception is available, many potential users lack knowledge and support, have a lot of fear, and face formidable social and cultural barriers to using contraception."

"Lack of knowledge" in survey responses can actually mean an absence of family planning services or information, says Dr. John Ross, who coordinates unmet need studies for The Futures Group International, a U.S.-based organization that studies reproductive health issues. This can be particularly important for certain population groups, he adds, especially postpartum women, adolescents and women living in rural areas of many countries.

"About 40 percent of unmet need falls in the first year postpartum," he says. "Working to join services across institutional gaps can help address this need." Linking family planning services with childhood immunization, oral rehydration treatments, and other early childhood services can make contraception available when a large amount of unmet need occurs, according to Dr. Ross.

Lack of knowledge is also closely connected to women's status within their family and communities. A study in Guatemala examined patterns of communication and decision-making that affected unmet contraceptive need. Women with unmet need were more likely to be in families where control over fertility or family planning was not discussed or encouraged and where women did not participate in decisions concerning reproductive and sexual matters. The study, coordinated by ICRW, used survey data from 275 people and in-depth interviews with 80 people, including men and unmarried women.<sup>5</sup>

"Although men and women have access to information on contraceptive methods from television, radio, brochures and other sources, many of them do not have an opportunity to discuss it with each other, face-to-face," explains Dr. Linda Asturias de Barrios, who directed the study through ESTUDIO 1360, a Guatemalan research center. "Moreover, the available health services that do allow for face-to-face interactions, such as health centers and community distributors, generally do not promote a psychological atmosphere that permits women and men to discuss such sensitive topics as sexuality, reproductive health and family planning." To address the findings of the study, the project is training local health workers as counselors, identifying 50 young women to participate in an education project and designing a sexual health educational curriculum, among other efforts.

Like the Guatemalan project, several recent studies have shown that barriers to individual use are part of larger social and cultural patterns. Using in-depth interviews and focus group discussions along with survey data, studies in Ghana, India, Pakistan, the Philippines and Zambia, as well as Guatemala, consistently found that lack of knowledge, fear of side effects and husband's support are the major factors accounting for unmet need.

#### SIDE EFFECTS

In many studies, the impact of contraceptives on a woman's health, whether real or perceived, is often a barrier. Concerns include side effects and unfounded fears about side effects or health consequences, based on lack of knowledge or false information. In the Pakistan study, a large portion of women who had heard of modern methods feared harmful effects from using them, ranging from 40 percent for female sterilization to 70 percent for the intrauterine device (IUD). "The body remains impure ... with an IUD insertion," said one woman, apparently referring to how IUDs can alter menstrual bleeding. "The

### UNMET NEED

#### COUNTRIES WITH LARGEST NUMBER

Millions of married women of reproductive age

India	31.0
Pakistan	5.7
Indonesia	4.4
Bangladesh	4.4
Nigeria	3.9

#### COUNTRIES WITH LARGEST PERCENTAGE

Percentage of married women of reproductive age

Rwanda	37
Kenya	36
Malawi	36
Burkina Faso	33
Ghana	33
Liberia	33

Source: Robey B, Ross J, Bhushan I. Meeting unmet need: new strategies. *Popul Rep* 1996; J(43):7, based on Demographic and Health Surveys.

IUD causes bleeding and spotting. One cannot remain pure. Therefore, I got the IUD removed." The study involved 1,310 married women and 554 of their husbands in urban and rural communities.<sup>6</sup>

One way to address obstacles related to side effects, health concerns and incorrect knowledge about contraceptives is better counseling. Counseling about side effects can improve continuation rates, thus lowering the portion of women who may fall into the unmet need category. For example, in a study among women in China using the injectable depot-medroxyprogesterone acetate (DMPA), about 200 women received detailed counseling about side effects and about 200 received only routine family planning counseling. One year after the women began using the method, discontinuation rates were almost four times higher among the group receiving routine counseling, 42 percent compared to 11 percent. The main reason for discontinuation was menstrual changes, the most common side effect of the method.<sup>7</sup>

Many providers do not counsel women about side effects. In 12 counties in sub-Saharan Africa, only about half of the women who chose a new method received information on that method's side effects, according to a study of the quality of family planning services. The portion informed

about the method's side effects ranged from 24 percent in Burkina Faso to 68 percent in Botswana.<sup>8</sup>

## FAMILY ROLE

Another consistent finding among recent studies is the importance of men and other family members. In two studies in sub-Saharan Africa, in Ghana and Zambia, unmet need was higher among couples who did not discuss birth control with each other.

In Ghana, only about a third of women with unmet need felt comfortable discussing contraception with their husbands, compared to about two-thirds of contraceptive users. Both groups of women saw husbands as important in making a decision about contraception. The study concluded that "men must be reached, at least initially, through culturally appropriate communication channels."<sup>9</sup> For example, the Navrongo Community Health and Family Planning Project in Ghana does so through chiefs and heads of families.

In the Zambia study, done in or near a city, nearly nine of every 10 contraceptive users had at some point talked with their husbands about contraception. In contrast, only about two of every three women who had never used contraceptives but wished to avoid pregnancy had discussed contraception with their husbands.

When the research team presented results in community meetings, many participants urged that family planning information become available to men through neighborhood health committees. Men tend to gather at specific locations and times, creating opportunities to reach men with services.<sup>10</sup>

In the Philippines study, the researchers concluded that the difference in power between women and their husbands is a major factor accounting for unmet need. "Difficulties in initiating and refusing sexual relations characterize women with unmet need. In fact, unequal power between spouses in sexual matters often seems to complicate and exacerbate the other factors identified," concluded Dr. John Casterline of the Population Council and his colleagues. As one woman said, "Since he is my husband, his decision prevails." The study included surveys of nearly 2,000 women and men in Manila and a rural area.<sup>11</sup>

In recent years, programs in Colombia, Ghana, India, Kenya, Mexico and other countries have begun efforts to involve men in reproductive health programs. In the Philippines, for example, Dr. Cesar Maglaya, a former FHI research fellow, has begun a male clinic at Dr. José Fabella Memorial Hospital in Manila, providing no-scalpel vasectomy to husbands of postpartum mothers. "With men, it is a matter of reaching out to them with accurate information and education about family planning and reproductive health, which includes sexually transmitted diseases, so they will realize that men play an important role in reproductive health," says Dr. Maglaya. "Men are beginning to volunteer in getting other men to have vasectomy now. Reproductive health programs must find ways to involve men."

The Pakistan study found that nearly nine of every 10 women perceived men's disapproval of contraceptive use as an obstacle to meeting their reproductive needs. Pilot programs have sought to involve men in Pakistan, but sustaining that effort has been challenging. A project in the city of Mardan, for example, used community educators working through a male-controlled community development council to contact men and couples about contraceptive use. In four years, the contraceptive prevalence in the area rose from 9 percent to 21 percent. But funding for the project ended.

## CHOICES

Lacking a range of contraceptive choices can result in unmet need. Research in Vietnam found that expanding the mix of available methods should reduce unmet need substantially. The country has relied almost exclusively on the IUD, currently used by a third of all Vietnamese couples of reproductive age. "But it has stalled there for a number of years and is unlikely to go higher," explained Dr. Ross of The Futures Group International and colleagues in a recent paper. "Meanwhile, another one-sixth of couples have used it but stopped and they have only very limited choices. An unmet need focus, with a full choice of methods, would go far to correct this."<sup>12</sup>

In the 1970s and 1980s, adding a modern contraceptive method to a national program that was young and evolving often

resulted in a significant increase in contraceptive prevalence. Adding a new method increased prevalence by about 12 percentage points, according to a 1989 study.<sup>13</sup>

— William R. Finger

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## MOTHER'S AMBIVALENCE CAN AFFECT INFANT DEVELOPMENT

Adolescent girls' perception of their pregnancy can influence the health and well-being of their babies, according to research conducted by the Women's Studies Project at FHI.

In a three-year study in Fortaleza, Brazil, researchers at the Maternidade Escola Assis Chateaubriand (MEAC) and FHI examined 259 infants, measuring motor (movement of muscles), personal-social and language skills. Investigators found that whether a pregnancy was wanted or not had little adverse effect on infant development. Maternal ambivalence, however, played a much greater role.

Young mothers who were ambivalent about their pregnancies — who changed their minds during the study about whether they wanted the pregnancy — were more likely to have infants who scored below a specified target level on tests that measure child development. Infants were tested at about one year of age. Nearly 14 percent of infants with ambivalent mothers scored below target, compared with 7 percent in the group who consistently said their pregnancy was unintended and 5 percent in the group who consistently said their pregnancy was intended.<sup>1</sup>

"Those young women who were really adamant that they wanted the baby at first interview, then changed their minds, had the most problems. Those who acknowledged that their pregnancy was poorly timed seemed to rally and do their best to provide good child care," said Dr. Patricia Bailey, an FHI expert in maternal and child health, who supervised the research.

"It is encouraging to find that infants born to mothers who said the pregnancy was unintended do no worse than those whose mothers said the pregnancy was intended. However, these results show that as time passes, an increasing number of young women wish they had delayed their pregnancies."

A correlation was also observed between mothers' perceptions of pregnancy and infants who scored above target. Contrary to previous research in the United States, which indicates that women who wanted their pregnancies typically have healthier babies, adolescents in the "unintended pregnancy" group were twice as likely to have infants who scored above a specified target, compared with mothers who said their pregnancies were intended. Thirty-eight percent of infants in the unintended group scored above target, compared with 18 percent in the intended group and 31 percent in the ambivalent group.

Other factors did not appear to play a significant role in infant development. The mother's age, work or school status, marital status, self-esteem and postpartum contraceptive use did not affect infant development, nor did premature delivery, complications during pregnancy or delivery, attendance at well-baby clinics or breastfeeding.

### PROGRAM IMPLICATIONS

Since the majority of women in the study did not intend to become pregnant, the findings indicate a need for more information about sexuality, contraception and decision-making.

Programs that encourage young women to delay pregnancy until they are older should also consider the role of self-esteem. The proportion of young women with high self-esteem rose from 30 percent to 53 percent a year later. Self-esteem increased for both new mothers and abortion patients.

While adults view teenage pregnancy as risky to the mother and infant's health and detrimental to the mother's education and employment prospects, many young women find that having a baby boosts their sense of self-worth. Consequently, they do not see pregnancy as detrimental to their future. "Adolescents need pregnancy prevention, and they need to see they have other options for their future before taking on the role of motherhood," said Dr. Bailey.

The Brazil study surveyed more than 367 women ages 12 to 18 seeking prenatal services at MEAC clinics in Fortaleza and 196 women seeking treatment for abortion complications. Among other findings:

- School enrollment dropped from 52 percent to 31 percent over one year. Abortion patients were more likely to be in school.
- At first interview, many of the pregnant teens said their families and partners were excited about the pregnancy, and they believed their relationships would improve. At one year, the quality of relationships with parents had not changed significantly. Relationships with partners deteriorated for both the prenatal and abortion groups.
- At conception, contraceptive use was 3 percent among girls who said their pregnancy was intended and 17.6 percent among girls who said their pregnancy was not intended. After a year, two-thirds of all adolescents were using contraception, with highest use among mothers whose pregnancies had been unintended (75 percent).<sup>2</sup>

— Barbara Barnett

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# Resources

## FHI MODULE ON INJECTABLE CONTRACEPTIVES

**I**njectable Contraceptives, a training presentation in FHI's *Contraceptive Technology Update Series*, reviews the safety, effectiveness, mechanisms of action, characteristics, and potential side effects of injectable contraceptives, as well as related counseling and programmatic issues. A revision of the 1994 FHI module *Injectables*, this presentation covers depot-medroxyprogesterone acetate (DMPA), norethisterone enanthate (NET-EN), combined injectables and the World Health Organization's medical eligibility criteria for

the safe use of injectable contraceptives. The module, designed for family planning providers and program managers, includes 35mm slides, a narrative, audience handouts, reprints of key scientific studies and other resources. The module is available in English, with translations in



French and Spanish expected in late 1999. Copies are free to developing country providers and trainers upon written explanation of need, and may be purchased

by others. For pricing details or to obtain a copy, please contact: Ms. Carol Smith, Module

Project Coordinator, Family Health International, P.O. 13950, Research Triangle Park, NC 27709, USA. Telephone: (919) 544-7040, ext. 589. Fax: (919) 544-7261.

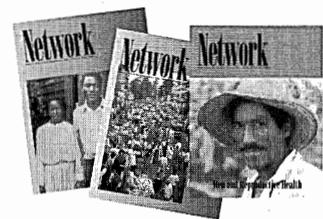
## EVER SINCE ADAM AND EVE

**E**ver Since Adam and Eve: *The Evolution of Human Sexuality* views the panorama of human sexual and reproductive behavior over centuries. The milestones of one's reproductive life, from birth to death, are examined in light of biological aspects coupled with the pressures from historical and contemporary cultures. The authors, Drs. Malcolm Potts and Roger Short, look at the past to make sense of

the present, to see how and why cultural influences arose, and how they contributed to human sexual behavior. Dr. Potts, former president of FHI, is Bixby Professor in the School of Public Health at the University of California at Berkeley. Dr. Short, former FHI board chairman, is Wexler Professorial Fellow in the Department of Perinatal Medicine at the University of Melbourne Royal Women's Hospital. The 350-page book with 50 color plates costs U.S. \$74.95 for hardback or U.S. \$29.95 for paperback, plus \$4 for shipping. To obtain further information or to order, please contact: Cambridge University Press, 110 Midland Avenue, Port Chester, NY 10573-4930, USA. Telephone: (800) 872-7423. Fax: (914) 937-4712.

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