

**Technical Report 17:
Contraceptive Discontinuation
and the Client's Experience
of Method Use and Services**

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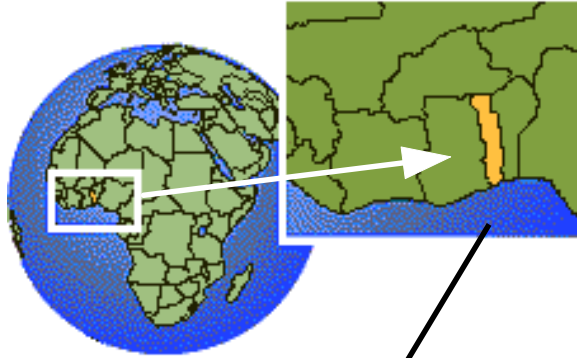
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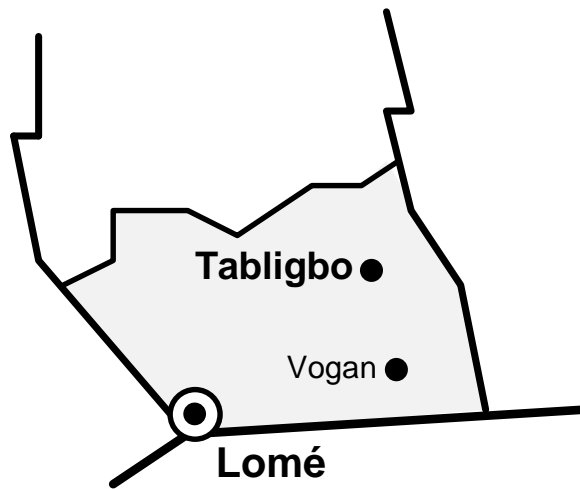
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M A P S

Where in the world is Togo?



The study area in southern Togo



Note:

1. The shaded area is Maritime Region.
2. The 2 main centers used are indicated in **bold**, the other three in regular font.

- **Bé**
- Nukafu
- Adakpamé

Executive Summary

Introduction

As Jain (1988) has pointed out, focusing on providing family planning services that more fully meet the needs of clients and on *retaining existing clients* not only improves the quality of care they receive but can also result in a larger number continuing on family planning than with strategies that focus more exclusively on *recruitment of new clients*.

Two thirds of fertile women in Togo definitely want to *space* (i.e. wait more than two years before giving birth to another child) or *limit* family size (i.e. have no more children). Across West Africa, one half to three quarters of fertile women want to space or limit. Yet from the most recent DHS surveys in all these countries, fewer than 10% are using modern contraception. In Togo, the figure is 8%. Twice as many have used in the past but have quit, most into in-need status. That is to say, only one-third of ever-users are currently using. This study seeks a better understanding of what leads contraceptive users to quit, particularly when they could still benefit from using. This information is sought to help orient efforts to make FP services more responsive to the needs of clients and so to better support them in their efforts to safely and successfully achieve their reproductive intentions.

Methods

This *qualitative* study was based in 2 settings, Lomé and a rural part of Maritime region. The main groups and data-gathering approaches were the following:

What method?	Who & how many?	From where?
1) in-depth interviews	40 current and former contraceptive users	through 2 public-sector <i>clinics</i> , 1 urban, 1 rural
2) focus group interviews	47 men, 4 groups (2 urban, 2 rural)	from the community
3) observations, pre- and post-consultation interviews	interaction between clients & providers (26 encounters)	in 5 public-sector clinics (3 urban, 2 rural)
4) in-depth interviews	9 service providers	from 5 clinics (as above)

Interviews and observations were tape-recorded, translated from the local language and transcribed into French. Analysis, using NUD*IST 4.0 software, involved a comprehensive code and retrieval process to generate key themes.

Results and Conclusions

Most women contacted who were lost to follow-up had discontinued into in-need status. Decisions to discontinue almost always resulted from the *interaction of several factors*. The most important can be grouped in 4 categories: 1) husband opposition, 2) fertility and health concerns, 3) side-effects, and 4) provider issues. For most discontinuing into in-need status, both side-effects and fertility and health concerns were involved. Most were injectable users & so, almost inevitably, experienced menstrual changes. *Beliefs* and *meaning* attributed to these changes were more often the key factor than pain, discomfort or inconvenience.

Decision-Making in Couples

Most men and women were motivated to limit the number of children to the financial means available to support them and modern family planning is increasingly acceptable. But men are less well informed about modern contraceptives, therefore more readily influenced by reports that they are harmful. It is still common for men to equate contraceptive use with infidelity, so they may oppose use even if they don't want more children. Despite recognizing the need for child-spacing or limiting, couples tend not to talk about these issues. So women find themselves in the awkward position of either deciding alone or doing nothing. Most men were offended at the idea of women making important decisions (such as beginning contraceptive use) without their knowledge, although a number acknowledged that in at least some circumstances it could be justified. This in fact is very common; many women are prepared to use even when their husbands are opposed. Typically those that do have some financial autonomy and, conversely, those who are financially dependent on their husbands don't feel free to do so.

A Woman's Bodily Experience

Beliefs about the consequences of contraceptive use, *symptoms* experienced while on the method, predictable *physiological effects* of the products, and the *provider's role* in anticipatory counseling and responding to concerns as they arise are all tightly entwined. This complex of issues played a part in most decisions to discontinue. Many still fear modern contraception, understanding it to lead to sterility or serious health problems. Legalization and government support for family planning in Togo date only to 1975 and 1987, respectively. Furthermore, many practitioners vividly recall policies, in effect into the 1990's, restricting availability to women who already had several children, the rationale being not to leave women permanently childless. The capacity to have children is highly valued and, in relation to contraceptive use, is seen to be somewhat fragile and vulnerable. Continued use by some providers of procedures intended to restore fertility after quitting contraceptives (vaginal lavage^{*}) reinforces the idea that they at least temporarily damage a woman's reproductive capacity and that active efforts are required to reverse these effects.

Menstrual changes associated with hormonal methods are a problem for many. However more common than the effects themselves being intolerable is that they are interpreted as signs that problems of sterility or serious illness could develop. Because many users believe losing one's periods is not normal, they are inclined to consider their amenorrhea as the *cause* for any symptoms or health problems they experience.

Provider and other Service -Related Issues

Providers generally spent little time assessing their clients' circumstances or eliciting their concerns. For first visits, most of the time was taken up with a standardized presentation on the different methods. Much of the information was irrelevant to the specific woman, so not surprisingly they tended to remember little, even of the parts more important to them. So women are frequently inadequately prepared to interpret or manage predictable side-effects that arise. Providers generally warn new clients they could experience menstrual changes, but such information tends to be vague and is generally downplayed. Women

* treatment used by some midwives for vaginal infections and infertility; the vagina is flushed with disinfectants diluted in warm water.

starting on injectables are *not* told that if they use for a year or more they are *likely* to become amenorrheic. When they return to clinic distressed about such changes, they are commonly told, “it’s not a sickness, it’s the effect of the product”. Although some are reassured, others are not. Against the word of the provider comes to bear the full weight of the traditional understanding of menstruation and reproductive function. Losing one’s periods is not normal unless one is pregnant or beginning menopause. If the blood isn’t coming out, where is it going and what is it doing to the body not to be able to get rid of that old blood? That some providers themselves harbor suspicions that their products sometimes cause sterility makes it difficult for them to convincingly reassure their clients.

Medical or procedural barriers contributed to discontinuation and loss of new clients before they even started. Most common was requiring that women either *be menstruating or have a pregnancy test done* before starting a new method. Providers insisted on these conditions even for women who had just discontinued other methods (IUD), had just completed menstruating, were still abstinent post-partum, or reported no sexual intercourse since last normal period. Since the test is relatively expensive, most new clients who are not menstruating ended up going home without their desired method. Both providers and clients reported that many such women don’t come back. A similar situation arises for established users on Noristerat[®]. Women returning late usually were refused their injection, even when they were only a few days late or reported not having intercourse since their missed due date. Several women reported such an experience, at least one of whom had become pregnant because of this requirement. Women were also denied methods due to *age* or, more often, to *weight*. Heavy women were told they were ineligible for Norplant[®], or in some cases for *any* hormonal method. In some cases women were told they were ineligible because they weighed *too little*. Such unnecessary exclusions in several cases led to discontinuation into in-need status rather than method switching.

When clients volunteer it, providers do learn details of their clients’ reproductive goals, the sexual networks they are part of, frequency of contact with the partner and possible *risks of STI/HIV*. However such information is not systematically sought. In most sessions with new clients, discussion of condoms and STI risk was one-way (provider-to-client) and very brief. Dual method use was never discussed. No effort was made to determine if the woman’s partner was a member of a high-transmitter group (e.g. long-distance driver). When women came to clinic with symptoms of STI, in no case was any provision made to treat the partner nor was there any discussion of condom use.

Providers were courteous with clients when observed, although many clients reported circumstances in which they were treated disrespectfully. This was particularly likely at times when there was large client volume, insufficient staff, and long waiting times.

Clearly many factors bearing on women’s decisions to continue using contraception are beyond the control of providers; attitudes and beliefs in the broader community, the way husbands and wives communicate and make decisions, and the role of peers. But how providers respond to their clients, the kind of relationship they develop with them, how they work with them in choosing a method and counsel them about what to expect, how they help them in using it and respond to them when difficulties or worries arise - all these are ways providers can help their clients more successfully use contraception and safely achieve their reproductive intentions.

Principal Recommendations

Below are listed the principal *issues* addressed in the study recommendations. More specific suggestions are included in the recommendations at the end of this report.

1. A Client Focus

- Instead of insisting “that these are the rules of our clinic and you, as a client, have to accommodate to our ways of delivering services”, the program and clinic services need to be responsive to clients’ needs and preferences.
- Providers should be seen by their clients as helpful, available partners who can assist them in dealing with any problems or concerns.
- Avoid long waiting times

2. Access and Availability

- Eliminate inappropriate medical or procedural barriers, notably the menstruation requirement (and weight criteria).
- Integrate STI/HIV treatment and prevention more fully into family planning service delivery

3. Helping Women Start and Successfully Continue Using Contraception

Counseling needs to be much more *interactive*, eliciting client’s circumstances, her preferences, her explanatory model for menstruation and fertility and her beliefs about the effectiveness and safety of available methods.

Information given needs to be *individualized* and she needs to be assisted in coming to a method choice appropriate for her. She should receive enough pertinent information but not be swamped with masses of irrelevant detail. She needs to know what to expect when she goes on the method and what to do if she has problems.

a) Counseling on Menstrual Changes

- Both at first visit and on an ongoing basis, women’s concerns about menstrual changes (and especially loss of periods) need to be discussed in detail. How they understand physiology and the significance of menstrual changes needs to be respectfully elicited.
- Misconceptions need to be explicitly addressed. It is not enough to dismiss a woman’s concerns and simply to say, “it’s normal; it’s just an effect of the product”.

b) Dealing with Fertility and Health Concerns

- For many women it is not effective just to include, in a standardized presentation of methods, a brief claim that the woman will have no problem conceiving when she quits.
- Women have specific concerns that need to be addressed individually. It is therefore appropriate as a standard part of counseling new clients to ask what the woman has heard about the possible effects of these products and what she thinks. Again, such information has to be respectfully elicited and where there are important misconceptions they need to be directly & respectfully addressed.
- IEC work addressing common misconceptions about negative effects of modern contraceptives needs to take culture seriously, seeking ways to correct misconceptions that successfully bridge between traditional conceptual models and modern biomedical understanding.

c) Equipping Providers to Manage Side-Effects

- Providers need a good understanding of the mechanisms of action of methods and management of common side-effects

4. *Male Role*

- Men need basic information on family planning, addressing factual misconceptions.
- Deeper issues of male-female power balance are less easily addressed, but those in the family planning sector can partner with other social movements to advance these issues.

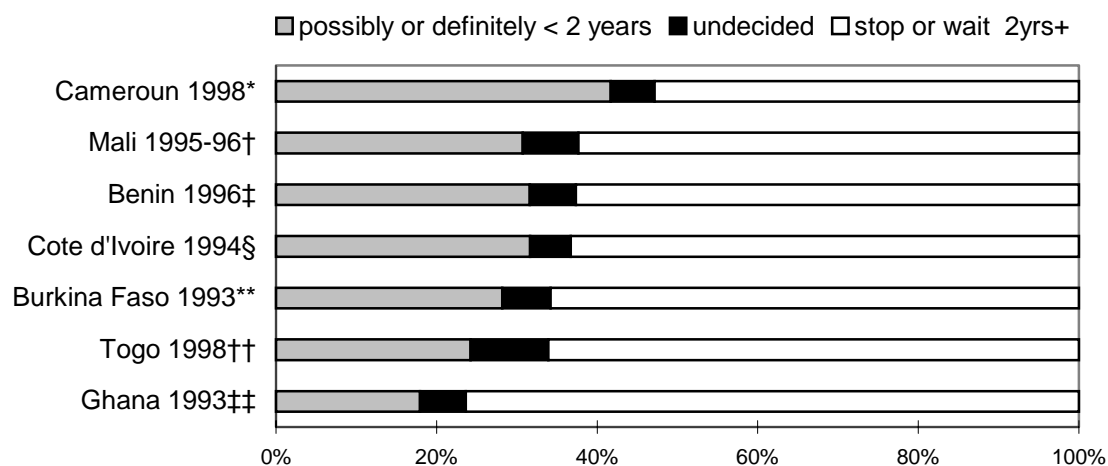
1. Introduction

1.1. The Context

According to the 1998 Togo DHS (Anipah et al., 1999), 2/3's of fertile Togolese women definitely want either to have no more children or to wait at least 2 years before the next birth. However, only 8% reported currently using modern contraception. More than twice as many *have used modern contraception* at some time *in the past* but for whatever reason are *no longer using*.

Mauldin and Ross (1991), reviewing DHS data from 44 countries, found that Togo had the highest proportion of married women of reproductive age with unmet need for birth spacing or limiting, 40%. However, Togo is not unique in having a high level of unmet need. Potential demand for modern contraception is at similar levels across the countries of West Africa. In all of these countries the *majority* of fertile women surveyed in recent DHS surveys responded that they either wanted to wait 2 years or more for the next birth or not have any more children at all.

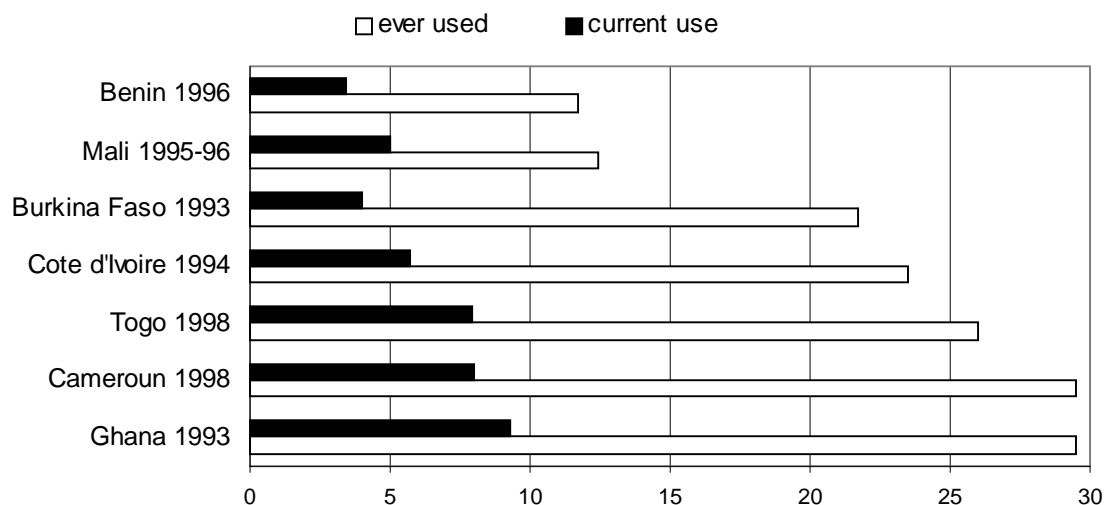
Figure 1: Fertility Intentions (DHS)



Similarly (as shown in Figure 2), across the region the prevalence of current use of modern contraception ranges from 4 to 9%. However, typically 1½ to 3 times as many have used in the past but are no longer using. Although the proportion cannot be calculated from published DHS reports, one can safely assume that many of these former users fall among the majority (observed above) who want to delay or terminate future child-bearing. These, we could refer to, then, as in-need discontinuers.

* (Fotso et al., 1999)
† (Coulibaly et al., 1996)
‡ (Kodjogbe et al., 1997)
§ (Sombo et al., 1995)
** (Konate, Sinare, & Seroussi, 1994)
†† (Anipah et al., 1999)
‡‡ (Ghana Statistical Service, 1994)

Figure 2: Contraceptive Use in West Africa (DHS)



It seems that many women do not perceive modern family planning methods or products to be accessible and/or appropriate means of achieving their reproductive goals, despite having used them in the past. Why is that? This study seeks to answer that question.

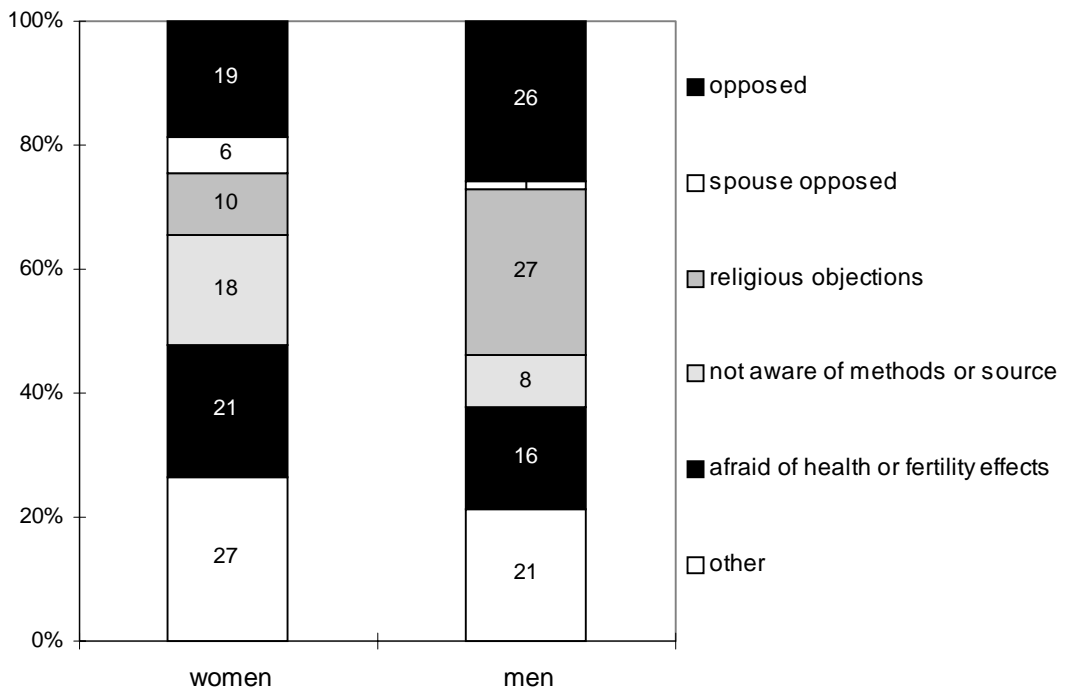
DHS data provide other helpful background information on the context in which this study was conducted. Two DH surveys have been conducted in Togo; data for the second were collected in May and June of 1998, 8 months before data gathering for the current study.

Table 1: Basic Demographic Data DHS 88 DHS 98

	DHS 88	DHS 98
<i>Total Fertility Rate (15-49, over past 3yrs)</i>	6.9	5.2
Woman approves of modern methods	69%	72%
<i>Ever used modern methods</i>	11	26
<i>Current modern method use</i>	3.4	7.9
• condom	0.6	3.4
• injectable	0.2	1.7
• oral contraceptive pill	0.6	1.1
• IUD	0.6	0.8
• Norplant	0	0.4
• sterilization (female)	0.6	0.3
• spermicide	0.8	0.2
Current modern method use - Lomé	6.9	10.7
Current modern method use - rural	1.7	5.5
Current modern method use - rural Maritime		4.7
<i>Current traditional method use</i>	29.1	17.2
• prolonged abstinence	17.5	8.1
• periodic abstinence	9.6	8.1
• withdrawal	2.0	1.0
Postpartum abstinence - median duration	17.5 months	13.4 months
Postpartum amenorrhea - median duration	14.4	14
Breastfeeding - median duration	22.6	24.3
Infant mortality (past 5 yrs)	80 /1000	81 /1000
Under 5 mortality	158	146

In summary, the total fertility rate remains relatively high but has dropped. A growing proportion of women have tried modern contraception although the level of current use is still below 10%. Use of condoms, injectables, and Norplant[®] has increased. Not surprisingly modern contraceptive use is most widespread in Lomé however, between the 2 surveys, there has been a greater than 3-fold increase in use in rural areas. Over the same period, traditional method use has declined by an even larger margin than the increase in modern method use. The proportion reporting currently using prolonged abstinence to avoid pregnancy dropped by over half, from 17.5 to 8.1%. So it appears there has been little change in the proportion of women taking active measures to avoid pregnancy; what has changed is that fewer are using traditional methods and more are using modern methods. The 1998 DHS also provides information on the reasons why many of those who could benefit from using modern contraception nevertheless chose not to use. Figure 3 presents the reasons for non-use given by women and men, in-union, who are not using, do not intend to start, and are at risk of an unwanted pregnancy.

Figure 3: Those In-Need, by Reason for Non-Use (Togo DHS 1998)



1.2. Why Study Discontinuation?

Certainly, program managers in Togo are concerned about service quality, however a more pressing priority has been improving *access*. Until very recently the primary concern in most family planning programs worldwide has been to achieve maximum coverage of populations with contraceptive services in order to reduce population growth. This orientation has led to measuring program effectiveness by adoption rates and prevalence of contraceptive use. Jain (1988) has argued that family planning services seeking to ensure good program support to a smaller number of contraceptive users can result in more effective and longer-term use and ultimately a larger proportion of the population effectively covered than those enrolling large numbers but losing equally large numbers to discontinuation.

A variety of factors undoubtedly play a part in influencing decisions people make about using or not using contraception, and more specifically - once one has started - deciding to continue to use or not. What makes discontinuation potentially a concern for family planning program managers and care providers is that women end up discontinuing despite continuing to be sexually active and yet not wanting to get pregnant. Many women (and couples) fall into this category. Certainly there are varying degrees of motivation not to get pregnant and consequently varying degrees of unmet need. However, it appears that many women who fall into this category could benefit from services and contraceptive products that better respond to their particular circumstances, concerns, and needs.

In most settings there are significant gaps between, on the one hand, the needs and life circumstances of clients and, on the other, caregivers' awareness of and appropriate response to those needs (Cooper, Diamond, & High, 1993). Yet, the published research literature is not well developed on women who have dropped out of family planning programs, their circumstances, needs and experience with service providers. Moreover, the few studies that examine these issues use research methods that fail to capture the complexity of women's experiences and decision-making processes.

Edah (1997) conducted a descriptive study in Togo explicitly investigating the problem of discontinuation. He followed-up almost 400 *discontinuers* from family planning services in southern Togo. Although the study provides much useful information, it did not examine how discontinuers differ from continuing users. Also, it did not investigate in any detail the particular circumstances leading to women's discontinuation decisions. The current study investigates the experience of both continuing and former users.

A small number of *qualitative* studies on discontinuation have used focus group interviewing (Loza, Sayed, & Potter, 1991; Sadana & Snow, 1999; Tolley, 1997). Although this method can generate greater richness of detail than survey methods on the experiences of women who discontinue, it may not be the best way to inquire into influences on *individual* decision-making, particularly in an area as sensitive as contraceptive use decisions. *No* studies in the published literature (or in the gray literature identifiable through POPLINE) have used qualitative in-depth individual interviews with women who have dropped out of family planning programs.

There are a wide range of factors that may influence women to discontinue contraceptive use despite what could be characterized as continuing need. This study seeks to characterize, from the full range of possible influences, those factors most salient to Togolese women focusing particularly, however, on service-related influences and especially on client-provider interaction.

1.3. Goals and Objectives

This study seeks a better understanding of what leads contraceptive users in Togo to discontinue, particularly when they are still in-need. Specific research questions include:

1. What *user*-related factors influence decision making about continued contraceptive use (especially discontinuation while still in need)?
2. What *socio-environmental* factors influence discontinuation?
3. What *service-related* factors :
 - a) related to *client-provider interaction* influence discontinuation?
 - b) related to other quality and access issues influence discontinuation?
4. How are such influences *integrated* and *processed* by users as they come to decisions about continuing use?

The reason for seeking this information is to help orient efforts to make family planning services more responsive to the needs of their clients.

2. Methods

Methodology is dealt with in some detail in this report, largely for the benefit of others who may undertake similar studies in the future. At least some other readers may want to only skim this section and move directly to the results.

This was a *qualitative* study based in 2 settings, Lomé and a rural part of Maritime region. Current and former contraceptive users (mainly those discontinuing into in-need status), recruited through 2 public-sector clinics and mainly using injectables, participated in *in-depth individual interviews* in their homes (n=40). *Focus group interviews* were held with *men* recruited from the community (4 focus groups, with a total of 47 participants). *Clinic-based observations and interviews* with *clients* and *providers* were conducted in 5 clinics, 3 in Lomé and 2 in the rural part of Maritime region. Most interviews and observations were tape-recorded. All were translated and transcribed (in French). Analysis was done using NUD*IST 4.0 software. A comprehensive code and retrieval process was used to generate key themes. Study results make use of extensive verbatim quotes.

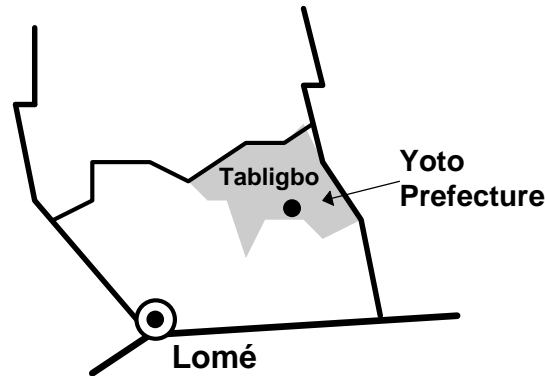
2.1. Study Setting

As a qualitative study, no effort was made to achieve statistically representative sampling. Nevertheless, even within the modest scope of this project, sampling was designed to maximize diversity between study sites and among participants. For *in-depth interviewing of current and former family planning clients*, a little over half the sample was recruited through an urban clinic and the rest from a rural clinic. The urban site was a clinic at the Hôpital Sécondaire de Bé (HSB); this is a relatively large-volume family planning clinic with a reputation for providing a high quality of service. Relatively large volume was required in order to provide an adequate number of study participants. A higher quality center was preferred so that what service quality issues that emerged would likely also affect many other centers. Other factors influencing this choice included HSB's active health committee and community-based distribution services, both of which were expected to greatly facilitate field work (as indeed they did).

For the selection of a rural site, service volume also needed to be sufficient to provide enough study participants. For budget and logistical reasons it was also necessary that the site be fairly close to Lomé. Although the site chosen (Yoto prefecture Health Center, in the town of Tabligbo) was in the Maritime region close to Lomé, contraceptive prevalence in this region is in fact less than half that of Lomé and barely above that of Savanes region, which has the lowest rate in the country. To make the Yoto sample as different as possible from that of HSB, the majority of Yoto study participants were recruited from outlying villages rather than from the town of Tabligbo.

Note that for *clinic-based* interviews and observations, the settings included the above 2 clinics and 3 *other clinics*, 2 in Lomé (Adakpamé and Nukafu) and 1 in Vogan, a market town in Maritime region, 15 miles south of Tabligbo. Figure 4 shows the location of Yoto prefecture (see also the map on page iii.)

Figure 4: Location of Yoto Prefecture



2.2. *Administrative Preparations*

Before the field work began, the project proposal was submitted to the Division de la Santé Familiale (DSF) at the Ministry of Health (MOH) and discussed between DSF managers and staff at PRIME/INTRAH's Lomé office. Approval was given and a DSF researcher was assigned as the project's main contact person in the MOH. From the beginning of the field phase, a staff member from PRIME/INTRAH Lomé was assigned as the main local counterpart to the principal investigator. At the beginning of the field phase, meetings were held between PRIME/INTRAH staff (principal investigator and local counterpart) and senior MOH managers in the DSF, the public health offices of Lomé-Commune and Maritime regions, and the Direction générale de la santé. They were each provided with summary versions of the project proposal and each gave formal approval for the project. Also during the first week of the field phase, PRIME/INTRAH staff began the selection process for research associate trainees and visited the proposed clinic sites (1 pilot and 5 study sites), meeting with clinic managers. The purpose and conduct of the study were explained to them and plans made for the timing of clinic-based activities. Similar visits were also made with the president of the Bé association of health committees, the coordinator of a community-based distribution (CBD) program in Lomé (SILD), and the secretary-general of Yoto prefecture. Arrangements were made for recruitment of potential study participants.

2.3. *Training and Piloting*

Training lasted 5 days. Participants included PRIME/INTRAH staff, the DSF contact person, the project translator/transcriber, and 7 prospective research associates. The first day and half were largely theory, discussing the use of qualitative research methods and client-provider interaction. The next day and half were spent largely doing simulated interviews and observations and the final 2 days were spent doing practice client interviews at the pilot clinic site. These 2 days also provided the opportunity for piloting instruments that had been prepared, as well as for evaluating trainee performance. At the end of the 5 day training, 4 interviewers were chosen.

2.4. *Project Staff and Associates*

Staff hired for the study included a project secretary, a translator/transcriber and 4 (female) interviewers, 2 of whom (the "senior interviewers") were retired midwives/medical assistants and 2 were masters-level trained sociologists (the "junior interviewers"). All 4 had some experience as field-research workers. In addition to staff hired for the project, a

PRIME/INTRAH staff person provided significant administrative support and participated in field-based analysis and other aspects of the work. A researcher from the DSF conducted the focus group interviews with men and a public health physician from the Direction Régionale de Lomé-Commune participated in the analysis and provided other support.

2.5. Sampling and Recruitment

In common with most qualitative studies, the sample size for this study was small and no effort was made to form a representative random sample of service delivery sites or users. This does not however prevent us from drawing conclusions that are more broadly informative or useful. But the way the sample was formed must be carefully considered in judging the broader relevance of the study's findings. Five clinic sites, 3 urban and 2 rural, were used for *observations and in-clinic interviews* of clients and providers. One each of the urban and rural sites was used to recruit current and former clients for *in-home intensive interviews*. Findings specific to 1 or 2 clinic sites may well reflect very local specific phenomena that may be either absent or much less significant in most other sites. However, since the 5 clinic sites used were chosen to be fairly diverse, findings evident from most or all 5 sites are likely to reflect conditions found elsewhere across the country. It should be noted that the 2 rural prefectures used may provide better geographic access than more remote areas in Togo. Therefore the relatively weak observed influence of geographic access on continuity of use may not reflect its importance in areas with fewer service delivery points or greater transportation difficulties.

Sampling of current and former users for *in-depth individual interviews* was done from 2 clinics, 1 rural and 1 urban. In identifying individuals for interviewing, the strategy was similar to a stratified random sample. Complete lists of clients lost to follow-up over the year preceding the study were drawn up, then stratified by neighborhood or village. Lists were also drawn up of current clients due for their next appointment in the coming 2-6 months). Potential study participants with inadequately specified addresses were excluded.

Table 2: Characteristics of Women Interviewed (n=40)

• age distribution	20-29 - 28%, 30-39 - 50%, 40 and over - 22%
• mean (& median) number of living children	4
• mean duration of completed schooling	3.6 years (15 had none, 5 had more than 7 years)
• last method used	Noristerat [®] - 29, IUD - 4, Pill - 3, Norplant [®] - 3, condom - 1
• mean duration of abstinence after last birth	7.8 months
• ethnicity	Lomé - most were either Ewé or Ouatchi (2 closely related ethnic groups) Yoto - almost all were Ouatchi

Neighborhoods and villages were visited across the catchment areas for the 2 clinics used and women in these neighborhoods whose names appeared on our lists were approached to be invited for interviewing. Recruitment was done by CBD workers in Lomé and by a junior clinic staff person in Yoto prefecture.

Given that the catchment populations for the 2 clinics chosen were quite different in many respects, findings *common* to the 2 groups of interviewees are likely to reflect experiences of clients of many other public sector clinics. Findings which differ significantly between the 2 groups are less easy to interpret. Some observed differences would certainly be due to the rural-urban difference. Others would be due to differences in service volume and staffing between the 2 clinics. There may however be yet other factors at play (related for example to differences in institutional culture). To make findings more readily interpretable, in the results and discussion sections it will be clearly indicated which findings are broadly represented across sites and which are specific to a single clinic site or to only 1 of the 2 groups of in-depth interviews.

For the *focus group interviews with men*, local community development workers were instructed to recruit men aged 20-40, married or otherwise in-union, and representative of the 2 clinic *catchment areas* (but not necessarily of clinic clientele) with regard to socio-economic status and occupation. In the rural site, they were recruited from all parts of the prefecture. For the urban site, they were recruited from neighborhoods near the clinic (from which over half of our female interviewees were recruited). These are *not* husbands of the women interviewed. Unlike the women interviewed, who were recruited through *health facilities*, the men participating in focus group interviews were recruited from the *community*. Because of how they were recruited the male focus group participants may systematically differ from husbands of the women interviewed, Indeed as seen in Table 3, the men interviewed had, on average, fewer children than the women interviewed.

Table 3: Characteristics of Male Focus Group Participants (n=47)

• age distribution	20-29 - 40%, 30-39 - 45%, 40 and over - 15%
• number of children	36% had none, 36% had 1 or 2, the remaining 28% had 3 or more
• occupation	most, in both urban and rural settings, were tradesmen

They may differ in other respects. Public clinics are attractive as a source of reasonably-priced *discrete* methods (like injectables and IUD) favored by women who are using without their husbands' knowledge. It may be therefore that a larger proportion of husbands of our female interviewees are opposed to contraceptive use than among men participating in our focus groups. The views of members of our focus groups should be interpreted as more representative of norms among male members of these *communities* than of views held by *husbands* of our female interviewees.

Similarities were evident between the 2 sites. Views or experiences common to the 2 groups are likely widespread in elsewhere in Togo. Differences also exist, with participants from the rural site tending to express more conservative views. While such differences may reflect urban-rural differences across the country, one cannot rule out other local cultural factors accounting for at least some of the observed differences.

2.6. Study Mechanics

Field work for the study lasted 10 weeks:

- weeks 1 and 2 were used for administrative and training functions,
- weeks 3 through 8 for data-gathering and processing, and
- weeks 9 and 10 for analysis and feedback of preliminary results.

The PRIME/INTRAH office in Lomé was used as the work-place (although, as described below, interviews were done off-site).

For each of the main study sites, lists were formed of clients who had been *lost to follow-up* (last missed appointment between 1 Jan and 31 December 1998). A second list for each of the 2 clinics was prepared, with names of *current* clients. Names were grouped by neighborhood or village. Staff of the community-based distribution program (or the clinic) then used the lists to recruit women for interviews. Within the following 2 days, pairs of interviewers visited the women in their homes to conduct interviews. Initial screening questionnaires were conducted and results used by interviewers to determine if potential study participants would be asked to participate in in-depth interviews (the sample focused mainly on women discontinuing into in-need status). The recruitment and administration of screening instrument were conducted so as to protect those using without their husband's knowledge.

Interviewer pairs then conducted and audio-taped in-depth interviews in Ewé. After the interviews, they reviewed the tapes and produced expanded field-notes (in French). This generally took each pair at least a half-day. Tapes were then given to the translator/transcriptionist who produced independent French translations of all the interview material. These generally took approximately 8 hours per hour of recorded interview.



In addition to the 2 main study sites used for recruitment of current and past clients, 3 additional sites were used, for a total of 5 in which clinic-based observations and interviews were conducted. Each of these sites was visited by a team including the

principal investigator and 2 of the interviewer/observers. One of the 2 interviewers spent the morning observing encounters between clients and service providers (tape-recording some of them). Her notes were later transcribed as WORD files and tape-recorded clinical encounters were translated and transcribed. The second interviewer conducted pre- and post-encounter interviews with clients in the waiting area, taking notes that were later expanded and transcribed. For a subset of clients, pre- and post-interviews and verbatim consultation transcripts were documented. The principal investigator interviewed providers in French (documented by tape-recording) and completed a structured observation/inventory instrument. These recordings were later transcribed.

2.6.1. Urban Phase

In the clinic study sites, once a client is 3 months past a missed appointment, her patient record card is removed from the regular file and put in the lost-to-follow-up file. Cards for women at the Bé family planning clinic whose last missed appointment was from 1 Jan 1998 to 31 December 1998 were reviewed by project research staff. All those with addresses likely to be adequate to find the client were extracted and a list was built, which included about 200 names and addresses.

A similar list was drawn up of about 100 women who were due for their next appointment within the next 2 months. These lists were then reordered by neighborhood.

There is a community-based distribution (CBD) program affiliated with the Bé family planning clinic, providing a variety of services including follow-up in the home with Bé family-planning clients. Its catchment area covers approximately the eastern half of Lomé.

During the urban phase of the study, pairs of CBD agents met with project staff and were assigned neighborhoods and lists of clients to contact. They were to find women on the list and request their consent for a home-interview to be conducted within the following 2 to 3 days, and they were to determine at what time of the day our interviewers should come.

At the end of each day of recruitment, each pair of CBD agents returned to the PRIME/INTRAH office, reported back on who they had successfully contacted and recruited, and gave detailed directions on how to find the women. They were generally successful in making such contacts with 4 or 5 women a day. A larger number of names on their lists did not bear fruit, most often because the address turned out not to be specific enough or because the women had moved. Few women declined to participate.

Each pair of CBD agents did their recruitment activities for about 2 days. Altogether 5 pairs covered 5 different areas of the city, in the end covering much of the eastern half of Lomé.

Altogether 47 women were contacted by project recruiters in Lomé, of whom 38 were subsequently visited by project interviewers and completed the screening questionnaire. Twenty-three of those were invited to participate in in-depth interviews.

At the time of the first contact with project interviewers, a screening questionnaire was administered. In some cases, the in-depth interview was conducted at the same visit although in most cases this was done during a subsequent visit. The screening questionnaire provided information on the client's "in-need" status and general category of reason for discontinuation. It was on the basis of this information that the decision was made whether or not to request an in-depth interview. Our intention was to interview only a small number of women discontinuing to get pregnant or because they were not currently

sexually active and to focus primarily on those in “in-need” status. In fact most of the lost-to-follow-up clients contacted were in-need.*

During the urban phase, in-home interviews were conducted over a period of almost 3 weeks. The pairs of interviewers never did more than 1 interview a day. This usually occurred in the morning and interviewers spent the rest of the day reviewing the audio-tape and writing up (long-hand) expanded field notes which were, in effect, French transcripts of the Ewé interviews. Their notes were subsequently typed up as WORD files by the project secretary.

2.6.2. Rural Phase

Procedures followed for the rural phase were very similar to those followed in Lomé. The discussion that follows deals primarily with aspects of the rural phase that differed. One key difference was that in Maritime region all interviewing and clinic observation was done over a 6 day period, with pairs of interviewers generally doing 2 interviews a day. This left little time for writing up expanded field notes. Instead, most of these notes/transcripts were completed over the following 2 weeks back at our Lomé work-place. During the recruitment phase, in contrast to the urban site where *project staff* drew up lists of current and ex-clients, in Tabligbo the family planning *clinicians* preferred to do this themselves. They were given instructions and applied the same criteria as in the urban site.

In Tabligbo, there is no CBD program or workers, so a clinic worker (a nursing apprentice) fulfilled the same function that the CBD workers provided in Lomé, visiting clients in their homes to request their participation and to determine when our interviewers would most likely find them available. Twenty-seven were contacted by the recruiter, of whom 22 were subsequently visited by interviewers and completed the screening instrument. Of those, in-depth interviews were conducted with 17.

While in Lomé the sample was formed to give good coverage of all the major neighborhoods of the eastern half of the city, in Maritime region we drew most of our sample from outlying villages of Yoto prefecture rather from the town of Tabligbo itself.

Clinic-based interviews and observations were done in the health centers in Tabligbo and Vogan and followed the same procedures as for the urban sites.

2.7. *Techniques Used*

2.7.1. Individual In-Home Interviews

Altogether 40 in-depth home interviews were conducted with women, of whom 23 were in Lomé, recruited through the Bé family planning clinic, and 17 were in Yoto prefecture. It also turned out that 23 of the 40 were former users and 17, current users. During the interviews women were asked to give an account of:

- their experience with modern contraception and family planning services,
- factors influencing adoption and discontinuation decisions, and
- the role of interaction with their service providers on their continuity of use and in addressing any problems that arose (interview guide - see appendix)

* Of the 23 lost to follow-up with whom in-depth interviews were conducted and who reported having discontinued, only 2 discontinued to get pregnant or because of no need. Of 20 others lost-to follow-up, to whom only the screening instrument was administered, 5 were continuing users, 4 had discontinued to get pregnant or because of no need and 11 discontinued into in-need status.

2.7.2. Clinic-Based Observations and Interviews

In each of the 5 clinics, * the principal investigator and 2 of the interviewers spent 5 to 6 hours. The principal investigator questioned providers on their perceptions of factors influencing continuity of use, including aspects of client-provider interaction (CPI), they see as most important in supporting women's continued use, as well as on various other aspects of their practice. Altogether 9 providers were interviewed. The principal investigator also completed a general Situation Analysis-type service quality instrument (available on request).

One of the junior research associates interviewed clients one-on-one in the waiting room, documenting their clinic experience and determining the reason for their visit and their expectations (this was documented by detailed notes with no tape-recording). Usually 4 or 5 women were interviewed per clinic site.

One of the senior interviewers (a former midwife) sat in with the family planning service provider as she saw clients for the morning. Five or 6 client-provider encounters were tape-recorded (later to be transcribed in French). She also documented at least 3 encounters per clinic site using a CPI structured observation instrument.

Once those who had originally been interviewed in the waiting area finished their consultation, the junior interviewer met with them again to conduct a debriefing ("exit") interview to get the client's account of the consultation as well as a point-by-point report on the extent to which expectations she had expressed earlier had been met.

Altogether 26 clinic visits were documented with verbatim transcripts, before and after interviews or, in most cases, both.

2.7.3. Focus group interviews

Four group interviews with men were conducted, 2 in the Bé area in Lomé, and 2 in Yoto Prefecture. In total there were 47 participants. Interviews were facilitated by the DSF researcher and conducted in Ewé/Ouatchi. The interview guide focused on:

- 1) how decisions are made in the family and who decides what
- 2) decision-making roles and process with regard to issues of family size, birth spacing and contraceptive use

Group interviews were tape-recorded and translated/transcribed into French.

2.7.4. Round-Table Sessions

Four round-table sessions were held at the end of the period of field-work. They served both as a mechanism for early reporting of results and as a final wave of data gathering. The main purposes were reporting of preliminary in-the-field analysis and validation of preliminary impressions, however they were also used for further exploration of specific content areas - oriented by early findings (e.g. concerns about permanent infertility resulting from contraceptive use). The first session (in Ewé) - was conducted with a sample of 7 of the 23 current and former clients interviewed in Lomé. The second and third sessions were with providers and their immediate supervisors in the Maritime Region and in Lomé and the final session was with decision-makers and program managers. All 4 were tape-recorded and transcribed in French. Although facilitators of these sessions had specific issues to raise, discussion was less structured than in the focus-group sessions.

* Limited data were also documented for a 6th clinic used as a training and pilot site.

2.7.5. Other Methods Used

As mentioned above, a short screening instrument was used during the recruitment of women for individual interviewing. This instrument provides basic demographic and contraceptive use-status information (see appendix). Furthermore, informal interviews were conducted with program managers, pharmacy personnel, street peddlers of pharmaceuticals, herbalists, and others.

2.8. *Data Management*

All *clinic observation* and *one-on-one interviews* from current or past *clients* were conducted in Ewé. All of this material (with 1 exception) was audio-taped and then translated and transcribed into French. The 1 exception was in-clinic interviews with clients, field notes for which were taken in French at the time of the interview and subsequently expanded upon.

All of this audio-taped interview material in Ewé was independently translated and transcribed by *interviewers* and by the *translator/transcriber*, so for each there are 2 separate French text versions. Tapes of *client-provider encounters*, however were not subject to this parallel translation/transcription process and therefore are documented only as a single set of transcripts.

Similarly, the 4 *focus group interviews* and the *round-table session* conducted in Ewé were translated and transcribed in only 1 version, produced by the translator/transcriber. French transcripts were reviewed for accuracy by Ewé-speaking observers who were present at the group interviews. The *other 3 round-table sessions* and one-on-one interviews with *providers* were conducted in French; they were audio-taped and verbatim French transcripts produced.

All French written material is on diskette and hard-disk at the PRIME/INTRAH office in Chapel Hill. All French taped interviews are under lock and key in Chapel Hill. Ewé taped materials are under the charge of the evaluation officer in Lomé (under lock and key) and will be destroyed once analysis is complete. None of these data carry personal identifiers.

2.9. *Analysis*

2.9.1. Analysis During Field-Phase

From the beginning of data-gathering, taped interviews were promptly translated and transcribed and then reviewed by the principal investigator. This was done for 2 *quality assurance* purposes:

- 1) to orient him in giving feedback to interviewers on their *approach to interviewing*. On the basis of this early review, slight revisions were made to the interview guide and additional informal training was conducted (encouraging more open-ended probing).
- 2) to validate the quality, accuracy and appropriateness of the translations. The principal investigator had in hand both the translator/transcriber's and the interviewers' versions of transcripts. Feedback was provided, encouraging a more complete word-for-word *translation*. The principal investigator reviewed all interview material in both versions, reconciling the few inconsistencies found in discussion with interviewers and the translator.

As data gathering proceeded, the principal investigator reviewed transcripts, *coding* them by the main categories of research questions for the study. For this purpose, the interviewers' versions of the transcripts were used as they had been found to be slightly more complete and reliable.

Later in the field-phase other members of the study team reviewed transcripts and in the final 2 weeks of field work the whole team participated in extended review and discussion of the principal themes emerging from the data. It was on the basis of these discussions that preliminary reports were prepared for presentation during a series of round-table sessions held the final week of the field-phase. As described above (in section 5.7.4) these sessions served in part as a validation mechanism for the team's initial analysis and interpretation of the data.

2.9.2. Definitive Analysis

All interview and observation transcript materials were initially prepared as WORD files and, after re-formatting, imported into QSR NUD*IST* 4.0 qualitative analysis software. All materials were reviewed and coded in detail. Initial codes were based on the principal research questions. However other codes were added to reflect themes emerging from the data. Once all materials were coded, specific themes were investigated by retrieving and reviewing *all* pertinent coded passages and drawing out conclusions consistent with the material. In this way emerging impressions were tested to ensure they weren't idiosyncratic personal responses but reflected fairly the full testimony of study participants. Representative, verbatim quotes were chosen to illustrate the conclusions identified.

2.10. *Human Subjects Clearance*

During planning for the study, the draft protocol was submitted to the DSF of the Ministry of Health of Togo for review and was approved. The proposal was also reviewed and approved by the Institutional Review Board of the UNC-Chapel Hill School of Public Health. Appropriate measures were taken to ensure privacy for interviews; study records have been kept under lock and key and without individual identifying information.

* NUD*IST stands for Non-numerical Unstructured Data Indexing Searching and Theorizing

3. Results

From service statistics (Bé and Yoto), the number of *lost-to-follow-up* and *known discontinuers* are similar and together come to about the same as the volume of new clients. That is to say, existing clients are being lost at approximately the same rate as new ones are being recruited. According to providers, most *known* discontinuers quit specifically to get pregnant. That may well be true. However, based on findings of this study, very few of those *lost-to-follow-up* discontinue in order to get pregnant or because of no need: most discontinue *into in-need status* (21 of the 23 women interviewed who had discontinued).

Previous research (Edah, 1997) has identified the main categories of reasons leading to discontinuation. Notable among these (other than desire for pregnancy) are:

- side-effects,
- health (and fertility) concerns, and
- husband opposition.

Data from the current study confirm these general categories of influence, although provider- or service-related factors could also be appended. What this study adds is an assessment of the *interaction* of these influences. For most women in the study sample, although they may name one key issue, in almost all cases several contributing factors are identified. Furthermore, women describe sets of influences on their continued use which change over time.

The results section begins with findings on the interaction at the individual level of these already identified factors *leading to discontinuation*. However, in each case these factors can be considered subsets of more general categories of psycho-social phenomena bearing on women’s experience of contraceptive use.

Table 4: Influences on Discontinuation into In-Need Status

Specific Factors Influencing Discontinuation	Broader Aspects of Women’s Family Planning Experience
• Husband Opposition	Communication & decision-making process in couples, locus of decision-making, gender & power issues
• Side-effects	Bodily experiences (side-effects & other symptoms) & meaning attributed to them
• Fertility and health concerns	
• Provider or service-related factors	Characteristics of services & client-provider relationship as experienced by the client

Following the discussion of the interaction of multiple factors on the discontinuation decision, specific categories of influence will be addressed in turn. This discussion however will not be limited to the conventional categories of influences on discontinuation. Instead it is organized under the rubric of the more general categories listed in the second column of Table 4. In each case the themes identified in the data are illustrated with quotations from interviews and observation material, with current and former users, providers and male participants in focus group interviews.

3.1. *Multiple Interacting Influences*

Previous studies on discontinuation have used either cross-sectional survey or longitudinal designs. In some cases, multi-variate regression techniques have been used. This permits assessment of the independent contribution of various factors, e.g. method-type, parity, distance from clinic, etc. However such relative weightings are determined only for the *group* as a whole. Such methods still do not give insights into how *individual* women (or couples) integrate the various influences impinging on them and come to decisions about continuing use of a method. In this section, there will be a discussion of study findings on how multiple influences come together at the individual level.

3.1.1. Change in the Balance of Need vs. “Cost”

For all users, weighing in on the positive side (supporting continued contraceptive use) is the woman’s (or couple’s) motivation to avoid a pregnancy. Even if there are few negative factors, if a pregnancy is desired or if the woman is no longer at risk for pregnancy, naturally she is likely to quit. Decreased, but not absent, risk of pregnancy (i.e. husband away much of the time) can decrease motivation to continue; negative factors can then weigh more heavily. In the following passage, a first-time user from Lomé reports that with decreased risk of pregnancy because of infrequent sexual contact, her concern about rumors of harm from use of contraception became more salient. However, before quitting altogether, she sought the advice of health-worker friend.

People say that the injections cause sicknesses. That’s why I quit the injections, and also I know that when you’re on the injection you have to be having sex, but I was on the injections without having sex. I think it’s useless and it can cause illnesses. I’ve talked with quite a few people who tell me that it really could cause sicknesses. But I have a friend who works at the hospital. I went to see her to ask about this and she told me that it wouldn’t do anything to me and that I could stay on it as long as I wanted. With that reassurance, I went back for my injections. (9)

3.1.2. Husband’s Role in Interaction with Other Factors

The husband’s support or opposition and the woman’s response were always in some way involved. If the husband did not approve of contraceptive use, but did not contribute much financially to the family, the woman would be less inclined to submit to her husband’s will. Surreptitious use is common in such circumstances. Family and peers were consistently much less prominent as influences on use continuation. However, in several cases husbands were influenced by friends, acquaintances or other wives and, in turn, insisted on their wives discontinuing.

3.1.3. Menstrual Changes and their Interaction with Other Factors

Since the methods used usually produce changes in a woman’s pattern of menstrual bleeding, most users were challenged to respond to such changes. Some, well warned in advance by providers and reassured in follow-up visits, took such changes in stride even if they involved some inconvenience or discomfort. This was more likely if they were strongly motivated to avoid pregnancy, had a good relationship with the provider, and did not harbor strong suspicions about the possibilities of sterility following modern method use. Others however reacted with alarm to menstrual changes. Their husbands in turn could

* all quotations from in-depth interviews with current and former users are referenced to case summaries found in the appendices.

become worried, either about the possibility of sterility or about the expense of treating side-effects, and in several cases they ended up insisting that their wives discontinue.

Response to menstrual changes was very often influenced by traditional views on the meaning of normal or abnormal menstrual bleeding. Providers themselves sometimes contributed to the idea that if a woman became amenorrheic, blood from missed periods would build up inside and eventually have to be cleaned out if the woman were to be restored to fertility. Many women expressed fears that loss of their periods could result in sterility or serious health problems.

While providers usually mentioned the possibility of such symptoms when counseling new users, some women would not return to their providers for help or advice in dealing with such symptoms when they arose. For whatever reason, a problem-solving partnership between provider and client had not been established. In other cases women did come back to their providers and were reassured that what they were experiencing was in no way dangerous. In yet other cases, clients returned complaining of symptoms they were experiencing but left unsatisfied; either providers failed to adequately address their fears or they dismissed them out of hand.

3.1.4. A More Systematic Look at Patterns

As described in the introduction to the Results section (and consistent with the published literature), in the study data one can discern 4 broad categories of influences on women's decisions to discontinue into in-need status which capture most of the factors women reported. They include:

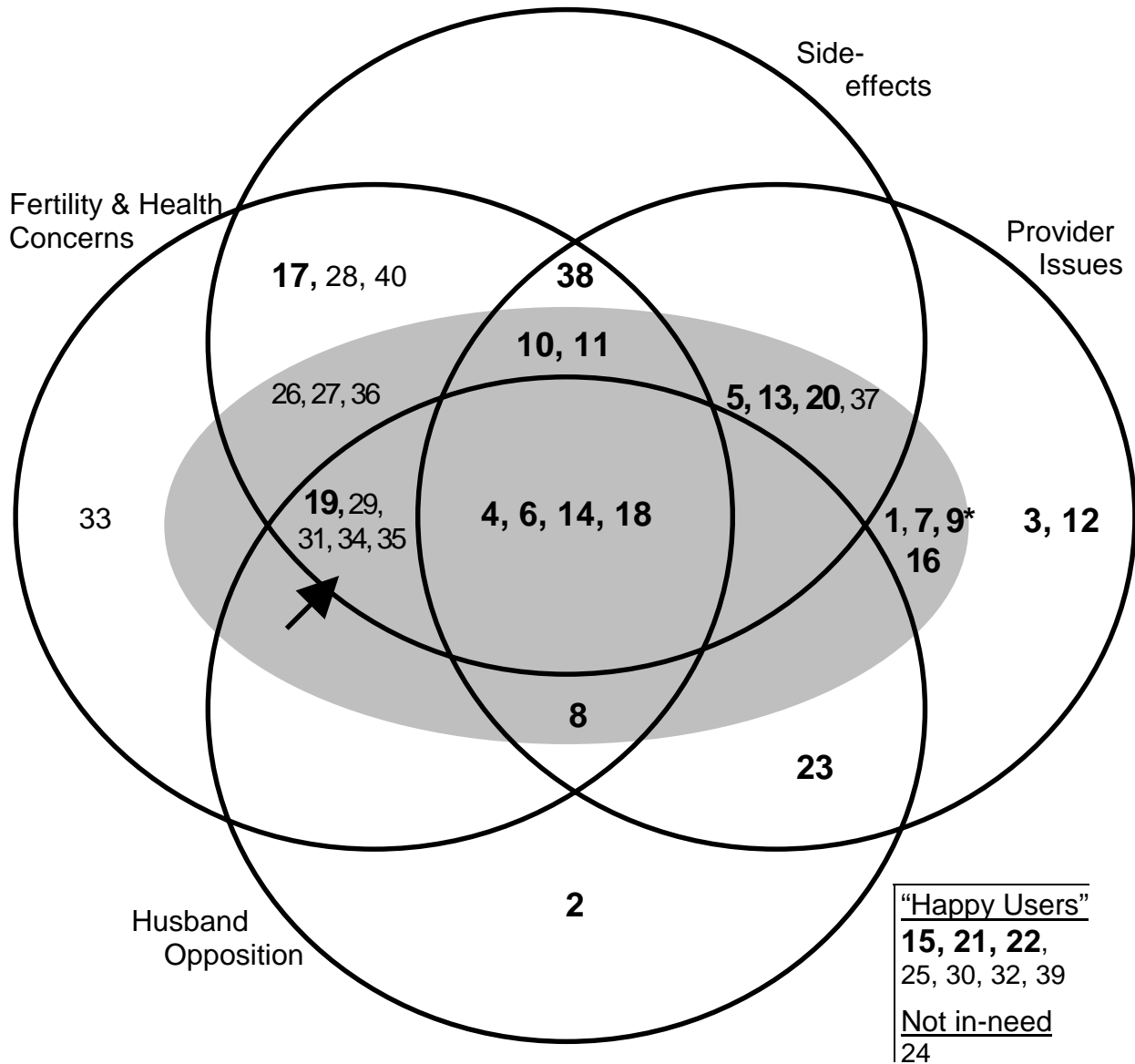
1. side-effects
2. fertility and health concerns
3. provider issues
4. husband opposition

In Figure 5, the 40 women with whom in-depth interviews were conducted are grouped by the sets of factors they identified as influencing their decisions. Those inside the gray area discontinued into in-need status, while those outside continue to use (or in 1 case discontinued into no-need status), although they may have experienced problems which have the potential to lead them to quit.

Clusters of cases sharing the same set of major influences are seen. Notable is that all but 4 of the 22 in-need discontinuers fall within the *overlap* of *side-effects* and *fertility and health concerns*. A more specific cluster within this broader grouping includes cases 19, 29, 31, 34, and 35, which also share *husband opposition* as an influence.

Four cases (4, 6, 14, 18) report *all 4 categories* of influence having had a bearing on their decision to quit using. Cases 5, 13, 20, and 37 all reported quitting due to a combination of *problems with side-effects and with services*.

Figure 5: Constellation of Factors Influencing Continuation



Notes on Figure 5:

- 1) All cases *inside* the shaded area above have *discontinued* into in-need status. Cases within the circles but *outside* the shaded area report factors which, although potentially significant, have *not* led users to quit.
- 2) Cases indicated in **bold** are from Lomé (urban); those in regular type are from Yoto (rural).
- 3) "Happy Users" are continuing users not reporting significant problems.
- 4) Case 9*, in addition to provider issues, also reported health and fertility concerns.
- 5) The segment marked with an arrow is discussed in the text.

Looking more closely at cases comprising these clusters yields other shared factors. Of the first cluster described (19, 29, 31, 34, 35), most have a number of other factors in common. Characteristics shared by most or all of this group (except case 19), as well as case 8, include:

- first-time contraceptive user on Noristerat[®]
- from a rural setting
- began using with her husband's knowledge and agreement
- developed menstrual or other side-effects, but they were *not* inherently intolerable to her in terms of pain, discomfort or inconvenience
- husband became alarmed, concerned about the risk of infertility or other serious health problem (in 2 cases, worried about the expense of treatments for side-effects or infertility)
- husband insisted that his wife quit, although she reported she would have preferred to continue
- discontinued and is now either pregnant or resigned to the prospect of an unwanted pregnancy.

The following is an account of the contraceptive use experience of one of the 5 cases in this cluster (case 34):

This illiterate 22 year-old mother of 2 lives in a village in Yoto prefecture. She was motivated to avoid pregnancy to advance her business, started on Noristerat[®] and used it for a year. She experienced menstrual changes (about which she was warned at her first visit) but after a time they frightened her. She reported going into the clinic frequently to treat her disordered menses. In the end her husband insisted that she quit because of the expense of these treatments. Almost a year later (after the study recruiter came visiting) she learned from her husband that he had discussed Noristerat[®] use with his other wife, a woman whose intelligence he particularly respected. She refused to use Noristerat[®], saying that it was harmful to health and fertility. He evidently took that advice to heart, particularly the suggestion that its use could leave his wives sterile. Furthermore, he had decided he wanted another baby. Her preference would have been to remain on contraception for another year but she felt she had to submit to her husband's demand (all the more so because he had taunted her as a sterile woman). When deciding to quit, she went to the clinic for a vaginal lavage in order to restore her fertility. She reports not telling others about her contraceptive use because it's seen negatively by many in this milieu (equivalent to killing babies) and can provide ammunition for attack. Her sister was harassed by co-wives for using contraception, supposedly so that she could get rich. Her sister ended up quitting but hasn't been able to get pregnant since quitting 3 years ago. This contributed to the interviewee's fears. After the interview, she reported that both she and her sister have experienced a number of episodes of pelvic pain and vaginal discharge. [Possibly their difficulties in conceiving could be PID-related.]

Note that all 40 case summaries are included in the appendix and the numbering of these cases corresponds to numbering used in Figure 5. As already noted, all quotations from in-depth interviews with current and former clients are referenced by case number.

3.2. Couples and Contraceptive Decision-Making

Logically one can approach contraceptive decision-making either as a couple phenomenon or as a function undertaken by a woman, with or without the support of her partner (indeed there are other options, e.g. as a task of the larger extended family unit). During the discussion of multiple influences on discontinuation, the male role was framed in terms of *husband opposition*. Discussed in this way, contraceptive decision-making is seen as a task of the woman, in which the husband's support or opposition is seen as one of a number of potentially important factors which she has then to integrate in coming to a decision to begin using, to continue, or to quit. In this section, there will be a discussion of study findings on communication and interpersonal dynamics as they influence decision-making in general, and fertility and contraceptive decision-making in particular.

3.2.1. Decision-Making Roles in Couples

Decision-making in couples was addressed in detail in one-on-one interviews with current and former users, with men in focus-group sessions in Lomé and Yoto, and in the round-table session held with current and former users in Lomé.

While in most other respects there were no striking differences between the urban and rural setting, on matters of decision-making roles between men and women important differences were present. Views which male focus-group participants themselves characterized as more traditional or conservative included the belief that the man is superior and should be the one, unilaterally, to make all important decisions in the household. Such views were reflected in the focus group interviews conducted in Lomé but were clearly the minority view. In focus group interviews in Yoto, however, such views were more widely held. The following is a fairly typical example of the more modern type of decision-making in couples, as described by a male focus group participant in Lomé.

In my home, for anything we have to do my wife and I sit down and talk about it... Everything we do we discuss together but, in the end, I'm the one to carry out the decision. Once everything is decided together, she tells me I'm the head of the family and it's for me to apply the decision. In my home, that's the way it is.

One participant in a Yoto focus-group described the more traditional arrangement:

In our region, women are under the domination of men. A wife follows her husband's orders and it is rare that the husband consults his wife before acting. Whatever the man says, the wife agrees without any argument. But there are some women who don't submit to these social requirements. Men aren't comfortable with women like that and aren't inclined to marry them. These days, some men are starting to realize that these traditions are out of date and that they need to change, but the change is coming very slowly.

Even in Lomé, most focus group participants agreed that it was legitimate for husbands to make some of their decisions without informing their wives.

I say that in a family when you want to do something there are certain things you tell your wife about and others that you don't have to tell her.

However, in general, both rural and urban focus-group participants agreed that it is inappropriate for women to make unilateral decisions without their husbands' knowledge, on anything but trivial matters.

Interviewer: In what circumstances can a woman make decisions without telling her husband?

Participant: I don't think I understood the question because it's obvious to everyone that men are superior to women. To suggest that the wife would make a decision without telling her husband - that can't happen here. All the wife can do without telling her

husband is things like buying some ear-rings or shoes, or cloth or creams. Anything more than that and she would have to leave.

Despite this general principle, in both settings male focus-group participants acknowledged circumstances in which husbands were acting irresponsibly and in which women therefore could be justified in making decisions without involving the man.

In different ways, many of those interviewed expressed the view that to the extent that one has *independent financial means* one has some *decision-making authority*. One former user in Lomé explained:

If it weren't for my husband I would keep getting the injections. But since he's the one with all the responsibilities - it's his pocket - I have to do what he says. I don't do anything on my own. He's the one who gave permission before and now he's the one who refuses. **(8)**

Typical of a number of surreptitious users, another former user from Lomé explains:

Interviewer: You never told him and for all this time you haven't got pregnant; doesn't he say anything about it?

Client: He doesn't give any support - so he has no right to ask me such a question. **(11)**

The following passage, from one of the Yoto focus-group interviews, expresses the traditional view on the man's authority over the woman. However he goes on to comment on how this natural order is disrupted when the woman has some degree of financial autonomy.

It's the man who has authority over his wife, not the reverse. When a woman starts making decisions without telling her husband she's on the way to divorce. A man can do certain things without telling his wife but a woman can't do anything without the approval of her husband because she belongs to him... The only thing that she can do without consulting him is prepare his meals... These days rich women do things like buying land and lots of other things without telling their husbands. Such behavior shows disobedience and disrespect for the husband; these are signs of future separation of the couple.

Another participant in the same session commented that such concerns justify the husband in preventing his wife from pursuing her own revenue-generating activities.

When a man finds that his wife has an opportunity to develop a successful business and make thousands and that this will give her power over him, he could refuse from fear that if she gets rich she could leave him. That's why women must always submit to their husband's wishes.

Another, addressing the same issue, takes the side of the woman.

Really, it's what the men do that leads their wives to hide their projects. There are certain men who are jealous of their wives especially if they see that their wives are making more money than them. They are afraid of being dominated by their wives - so they block all their wives good projects. So their wives end up making decisions on their own.

A number of study participants pointed out that communication dynamics differ considerably between *monogamous* and *polygamous* households. It was frequently argued that while more open discussion and joint decision-making was possible in a monogamous relationship, this becomes less feasible in a polygamous situation. On Lomé focus group participant had this to say:

When you have 2, 3, 4 wives, that's where problems start. With just one wife, everything can be discussed between the husband and wife.

One female round-table participant had this to say about difficulties in communication between spouses:

Most men have become like crabs with sharp claws ...It's late, nothing to be done now. My husband is afraid to say what he thinks. We never manage to discuss things together. The wise often say that to discuss things as a couple you have to choose the right time: at the evening meal, first thing in the morning... but unfortunately our husbands have become impossible. They throw words at us from a distance or when you want to talk to him and his parents are there, he doesn't answer and that's the end of it. So there isn't the communication between us and our husbands that we would have wanted... These days marriage doesn't make sense. You end up seeing that all we've done is make children.

3.2.2. Family Planning Decision-Making

Study participants' reports on how decisions are made about family size, spacing, and contraceptive use varied considerably. A few male focus group members argued for complete mutuality in decision-making about family size and use of contraception, although as the following advocate points out, this ideal is not often achieved.

Everything depends on the kind of relationship there is between the husband and wife. During their discussion of this question, whether it's the husband or the wife who brings it up, it shouldn't be done in a blunt way, as a decision already made. The person should lay out all the problems the family is having and have the other spouse review the situation. The other will end up convinced and will accept. And there will be agreement. Since there is agreement from the beginning, neither will refuse later on and it should go well. But many people don't do it that way, that's why there's disagreement on family planning.

A Yoto husband and wife discussed contraception. He was reluctant to have her start. She gave him an ultimatum: no contraception, no sex. He finally agreed.

Since I get quite sick when I'm pregnant and there's no money to support our children, I told my husband that we wouldn't have sex anymore unless we were using some form of contraceptive. He agreed and brought me to the family planning clinic. **(37)**

In the next passage, the wife raises the issue of contraceptive use with her husband, they discuss it and eventually she succeeds in getting his approval.

I talked with my husband about it but at first he wouldn't agree. So I came at in another way - I told him that the midwives wanted me to come for an appointment. He could take me there, I would tell him how it went and what they said and, whatever decision there would be, it would be for him to decide. It's not that they would ask him embarrassing questions. But still he refused. Finally I asked if I could go on my own and he accepted. **(26)**

From one of the interviews with a former user in Yoto, the husband decides his wife is to quit (because another of his wives has told him that the injectable can leave a woman infertile). His wife acknowledges his authority and submits.

Since he doesn't want me to keep using, I don't intend to keep tugging at him. He's the one who gave the money so I could start on the method. If I dared to oppose his will, it would be as if I was the one leading him. I want to submit to him. **(34)**

During a round-table session, a former user in Lomé reports a similar story.

Since I started with his permission and now he was giving me all these problems, I thought it would be best just to quit.

In other cases we see the husband influenced by certain factors and in turn insisting his wife take a certain course of action.

Interviewer: Did you quit because your husband refused or do you have your own reasons?

Client: Yes, I quit because he said the injections could cause problems for us. He said the injections could cause illnesses in me. **(29)**

However, the study sample includes many women who, when faced by opposition from their husbands chose to use contraception without their knowledge. Altogether 11 of the 40 current and former users who were interviewed reported using without their husbands' knowledge. In coming to such a decision, they needed to find discrete methods whose use they could keep hidden. Part of the attraction of public-sector clinics is their provision of such methods at a comparatively low price.

The men interviewed were, in general, offended at the idea of their wives making decisions without informing them, however several male focus group participants were prepared to acknowledge women's precedence in decisions about use of family planning. Two Lomé participants had the following to say:

Here women have a right because they are the ones to bear the full burden of pregnancy and child-birth.

For my part, the decision was taken with the full agreement of my wife. In a family, decisions about limiting the number of children are often made by both husband and wife. Even if you're not interested in the method and your wife goes to the clinic and is convinced by the information she gets there, you will end up agreeing to try it out. If it works, there's no problem.

Several women study participants (from Yoto) felt that in the event of disagreement between husband and wife, it was not justified for a woman to use without her husband's knowledge.

Some women would go on these methods but their husbands don't agree so they want to use secretly. But we tell them that that's the same as being unfaithful. **(37)**

A number of the men participating in the focus group sessions associated women's use of modern contraception with infidelity. Such views were expressed both in Lomé and Yoto, however they were more widely held by participants in the 2 rural focus group sessions.

While many study participants, male and female, took male infidelity for granted (indeed many saw it as a legitimate prerogative of the man), men took a far less sanguine view of infidelity by women. There was a lively debate during the male focus group interviews on whether or not women on modern contraception were more likely to be unfaithful. Several felt that, "when a woman is on the injections, she feels too free and she can end up committing adultery." Two others expressed similar views:

The woman feels protected because of the IUD. If there's a conflict in the home, she can have sex with someone else and not get pregnant.

Pregnancy is a way for the husband to maintain control and make sure his wife doesn't commit adultery... But if she knows she can't get pregnant she feels free to do whatever she pleases.

Others were also concerned about the link between modern method use and infidelity but felt that it was not so much that being on the method could *tempt* a woman, but instead that the desire to be on a method indicated that she was *considering* infidelity and this could help her keep it hidden. Here are the views of 3 participants from focus-group interviews in Yoto.

My wife came back from the clinic with this proposal. But I absolutely refused and went to the midwife to explain my reason to her - it's women who want to commit adultery who go on these methods.

Women use these product so they can have extra-marital sexual relations without their husbands knowing. Traditionally, you find out about cases of adultery by a pregnancy from another man. So some women use these methods to hide their adultery.

If she goes there without telling me, it's because she wants to go out and be a tramp.

Yet others were little inclined to associate contraception with infidelity.

There was adultery long before these methods. It's not because of these methods that women commit adultery.

If the woman wants to be faithful to her husband she can use these methods and she'll still be faithful, but if she's already spoiled she'll stay that way whether she uses these methods or not.

3.3. A Woman's Family Planning Experience

3.3.1. Motivation to Use

While there were frequent reports of peers or relatives saying that one should not inhibit or prevent the coming of children into the world - that that is the prerogative of God alone - most study participants (individual female interviewees and male focus group participants) saw birth spacing as positive. The most frequently given rationale was that one's family size should correspond to one's financial means. Otherwise one would not be able to provide the financial support necessary to assure them prospects for a happy future. Several study participants used variations on the following metaphor: "the more space between the plants the more they produce; but if they're planted too close they don't thrive." For a number of the women interviewed, despite facing a variety of factors which could undermine their continuing use (opposition from the husband, troubling side-effects, etc.), a strong motivation to avoid pregnancy sustained them in their continued contraceptive use.

3.3.2. Family and Peers

Culture is not dealt with in a separate section. But clearly social norms, shared values, and explanatory models are of great importance to individuals' experience and decision-making. By definition, such aspects of culture are internalized and shape how we see the world and how we manage its challenges day by day. Family and peers play a key role in mediating culture to the individual, providing the building blocks for making sense of one's experience as well as influencing the individual to conform to group norms.

Many of the women interviewed reported that information received from family or peers influenced their decisions to start using or to quit.

Often heard was that the woman's in-laws were opposed to her family planning use. One male focus-group participant had this to say:

Couples who adopt models at odds with their milieu run into problems even if they seem to be on good terms because their parents are opposed, especially from the husband's family. The culture of the region still has a very strong influence on families.

However, many vehemently denied that they were influenced by parents-in-law. "What my parents-in-law or other people say has no importance for me". (3) She went to say about her *mother's* influence:

I didn't tell my mother that I'm on the injectable; I don't want to tell her. Even if she knew she doesn't really have anything to say. She can't forbid my husband to do anything. Whether I have children or not is only mine and my husband's business. (3)

Similarly,

As for my mother, when I told her, she absolutely refused; she said that these things make you sick and that she never used them. "If you use them and something happens so much the worse for you." When I was sick we never told her that it was from the injection. If she'd found out, she would have hassled my husband. She would have given him a hard time because he'd agreed that I be on the method. So anyway, we never told her anything about it. (6)

One mother jumped in during an interview with her daughter (a former user) and angrily had this to say, "it's the injection that made my daughter sick; so I ordered her to quit" (4)

Sisters of contraceptive users were often reported to be supportive. A client visiting the clinic in Tabligbo had this to say:

Health workers come to our village from time to time to tell us about family planning. My older sister has used contraceptives and suggested that I try it. That's how I decided to start and I've been on injectable for a year and half now.

And from a former user in Lomé:

I didn't tell anyone except my 8 sisters. They thought it was good and they encouraged me not to have another child right away because I'm on my own taking care of my children and I'm suffering too much as it is. (7)

The following passage comes from a woman who ultimately discontinued despite continuing need. But at this point she reports on her struggle to integrating conflicting information from different *peers* during the time when she continued to use.

I talked about it with a number of people and they told me [the injections] really could make me sick. But one of my friends works at the hospital. I went to talk with her and she told me that I could be on the injection as long as I wanted and it wouldn't cause me any harm. That reassured me; that's why I went back to the hospital [to continue with the injections]. (9)

In other cases, *husbands* were influenced by *peers*, discouraging them from practicing family planning.

My main reason for quitting is this: friends of my husband came and told him that contraception can make you sick and sterile. So my husband said that there was no way he would have me doing sterility treatments: if using these things can cause this kind of problem, it's better just to quit. (8)

3.3.3. Bodily Experience and Meaning

On adopting a new contraceptive method, while women may experience no significant new symptoms, there are other possible outcomes. For certain of the hormonal methods there

are *predictable changes* in menstrual pattern likely to affect most users, notably irregular bleeding or loss of menses while on the injectable. There are possible *complications* to the use of family planning methods (e.g. thrombo-embolic events while on the oral contraceptive pill). And there are other symptoms users may experience, some of which are known *documented side-effects* (which may or may not be *tolerable* but which are generally not dangerous) and others which users may attribute to the method but are not physiologically directly related to method use. Bodily experiences and the meaning users attribute to them can be potent influences on women's decisions about continued use of family planning methods.

Symptoms Experienced

Since most of the women interviewed were on injectables, as one would expect most reported having experienced at least menstrual changes. Of the 17 *continuing* users,

- 4 were injectable users concerned to varying degrees over *loss of normal periods*,
- 1 (on IUD) reported pelvic pain, pain on intercourse and fatigue,
- 5 reported transient side-effects that resolved either spontaneously or with medication,
- the remaining 7 reported either no side-effects or effects that did not bother or worry them at all (usually menstrual changes).

Of all 40 women interviewed (continuing and former users), 14 reported an episode of method discontinuation in which side-effects were an important factor in the decision. Only 4 of the 22 discontinuing into in-need status did *not* report side-effects as having contributed to their decision.

Using Modern Contraception is Wrong

When women experience symptoms while using contraception they will attach more significance to them if they are feeling guilty about use or if they harbor fears about the method's possible adverse effects. Women also bring to their bodily experiences while on family planning methods models of how the body and its reproductive processes work.

One of the male focus-group participants made a clear statement opposing family planning on *religious* grounds.

If you think about these practices, you could say they're opposed to the Word of God, especially where it says, 'go and multiply'. If you limit births, that brings the curse of God. As far as I'm concerned, I'm against using these methods because no-one can know if there will be children, money or not. It's God who gives that, we don't have the power. If God gives me 10 children, he will also give me the means to raise them.

Religious objections were also mentioned by several current and former users interviewed but none were convinced by these arguments. This is not surprising: woman who have used will tend to be those less strongly opposed to their use on principle. On the other hand it is not surprising that some users are ambivalent about the moral basis for their contraceptive use. One current user (from Lomé) explained:

They say children are a gift from God, that you can only have by his will. That's certainly so, it's not good to limit births. My Jehovah's Witness religion doesn't allow it; it would be unfaithful to do that. **(12)**

However, she did not accept this as grounds for not using contraception herself. While she does object to such use by single women (because it implies extra-marital sexual activity), she sees no problem for married women.

One provider explained, “the Christian religion isn’t often an issue [with regard to opposition to family planning]; no, it’s more customs and traditions”. In fact several study participants invoked religious arguments *for* birth-spacing or birth-limiting:

To have too many children without having the means to take care of them is a sin against God. This is offensive to God and only causes grinding of teeth for Man. **(26)**

Another woman (the mother of a former user) sees contraception as inherently wrong, understanding the mechanism of contraception as keeping children in the belly and destroying them..

We don’t have the right to keep children from coming out of a woman’s belly. These methods destroy our children. **(4)**

Other study participants raised indirect objections, appealing to other moral values. One current user reported that her sister had been insulted by co-wives for avoiding pregnancy, which they equated with greed.

My older sister was harassed by her co-wives. They would say, “you’re just trying to get rich. That’s why you leave your babies at the clinic” [i.e. avoiding pregnancy by contraception but also implying that such practices are equivalent to abortion]; “We aren’t greedy for money; that’s why we’re still having babies.” **(34)**

Several male focus-group participants recognized traditional practices (prolonged post-partum abstinence, largely), as a form of birth-spacing and felt that the older ways are more acceptable. A rural male focus-group participant had this to say:

I’m against family planning because when you get married you should develop self-control and practice abstinence in order not to have births too closely spaced.

Another also endorsed the older ways but, rather than appealing directly to moral values, argued for such practices on the grounds that they sustained *men’s vigor*.

It used to be that husbands waited 3 years after the baby was born before sleeping with their wives and those men were strong and lived a long time, but these days men go to extremes, some having sex every day, most - every 2 or 3 days. Quite early, these men wilt away and become impotent, weak and sickly. Not at all like their grandfathers.

Using Modern Contraception is Dangerous

A much more important influence on the women we interviewed was the perception that the use of modern family planning methods could be *dangerous*. Contraceptives were not available in Togo until 1975, when condoms and spermicide were first offered through clinics run by the National IPPF affiliate (with the range broadened in 1980). Only in 1987 did the government of Togo begin to actively support family planning. Well into the 1990’s it was official policy to restrict injectable contraceptives to women with children, from fear of leaving a childless woman sterile. It is not surprising then that many people in Togo are still concerned about the safety of contraceptives.

As is the case with the perception of modern family planning being immoral, since the women interviewed had all adopted modern family planning at some point, one would expect them to be less influenced by rumors of dangers related to contraception than women who have never adopted. However, even in our sample this was a very common concern, and in most cases (15/23) contributed to the decision to discontinue. Indeed, of the 22 women discontinuing into in-need status, 14 reported quitting both because of side-effects and the perception that continued use posed dangers of either sterility or future health problems. For many, the experience of side-effects was taken as a sign of danger.

In a study done in southern Togo in 1991(Togo, 1991), including 2 of the 5 clinics from the current study, fully 45% of clients were IUD users (vs. 39% on injectables). Eight years later, there were very few IUD users in the clinics in the current study; over 90% of the clients in these clinics are now on injectables. Providers commented that IUD use is on the way out. They seem resigned to it disappearing from the scene. Almost half of the women interviewed in Lomé gave negative comments about the IUD (such comments were less common in the rural sample). A provider explained that a common perception of her clients is that, “if you get an IUD, it can go through the wall of the womb and into your belly; it’s not a good method.” Others equated IUD use with pelvic pain and infection. Several reported it could cause infertility or could cause miscarriages in the future.

As already indicated, injectables now dominate in public sector family planning clinics. Most women on these methods experience menstrual changes. *Menstrual blood*, according to many study participants, is meant to come out and if one employs a technology that prevents that from happening, problems will arise. As one provider explained, “They think that it accumulates in their bodies and will lead to problems. When they first come we explain to them but then they forget.” One woman was distressed by a change in the *character of menstrual bleeding* while on injectable and understood that the change, the “black blood”, was responsible for other symptoms she was experiencing. So she quit.

I planned to get my blood back to normal so I could get healthy and work again. I wasn’t getting well from my illness and I wasn’t putting on weight. I had muscle pains that were so bad I couldn’t leave my room. This was all because my blood was black. (10)

Several study participants who have used Noristerat[®] believed that non-menstrual side-effects occur because they *lose* their periods - “it’s because they [menses] don’t come out that I have these pains in my body”. (31) Two other former clients (from Lomé) reported:

When I was on the injection, I didn’t have my periods. When I told [the providers] about it, they told me it was from the injection. I had all the bad effects they talked about *because I didn’t have my periods*. This time, after my injection, I had a back-ache. I told myself the dose must be too strong for my system. That’s why I want to change. (11)

I was on the injection and I was doing fine, but after a while I started having various aches, in my back, in my neck. I couldn’t carry things any more. I didn’t feel well. I think the injections are giving me these problems *because I’ve lost my periods*. (18)

As one provider succinctly put it, “women say that if they don’t have their periods, they get sick”. Another provider reported the widespread belief that, “with Noristerat[®], if you lose your periods it’s not good; *women should always have their periods*”. Indeed, a continuing user (from Yoto) reported that peers believed that loss of menses from use of modern contraception could ultimately lead to *death*.

People say bad things about the injections. They say these methods can kill you and that Norplant will make you sick. If you use them, they’ll stop your periods and that will make you so sick you’ll need to go to the hospital; you could even die. (44)

The view is expressed that menstruation cleans the uterus and as such is necessary in preparation for conception. Indeed this is a view propagated by some *providers*. According to one - “you need to wait a while for your periods to come back to clean the inside of your womb. That has to happen before you can hope to get pregnant.” According to another:

If you want to quit the injections to get pregnant you have to wait for your next period before you could get pregnant because it’s your periods that clean the uterus. Just like you have to make your bed before you lie down to sleep, if your periods haven’t come to clean the uterus, you can’t expect to get pregnant.

Continuing normal menstruation is confirmation that one is not pregnant. Loss of periods (even while on contraception) can therefore raise fears of pregnancy.

I decided to quit the injections because 3 months ago I didn't have my period. I don't know if that means I'm pregnant. I'm going to go back to the hospital to see the midwives; they'll tell me whether I'm pregnant or not. **(35)**

Continuing to have normal periods also provides evidence that a woman is still in her fertile years. So as one of the clients interviewed at the clinic in Tabligbo reported, "when my periods got irregular I started to worry that it could be early menopause." If one loses one's periods, will they ever come back? Both clients and some providers see contraception as rendering women temporarily infertile and understand that, on quitting, active measures need to be taken to restore fertility. Here are reports by several women:

A midwife told me that when I quit the injection, if I want to get pregnant I should come see her and she could prescribe products to help me conceive. I told her I would. **(10)**

The midwives didn't say that I wouldn't ever be able to conceive. What they said was that if you stop the injections you could wait for a long time before getting pregnant. You need to find the money for treatments or go to an herbalist to get treated. After that you could get pregnant. **(16)**

Before quitting, I told my husband and he wanted me to get pregnant. I told him I would need go back to the clinic to get a vaginal lavage. **(34)**

The most common concern was fear that using contraception, especially injectables (and to a lesser extent IUD), could result in long-lasting problems conceiving or even permanent *sterility*. Most of the women interviewed reported having heard this. Two of them understood their providers to have given such information.

The midwife told me that, because of my age, if I used the injection and after 5 years I wanted to have a baby I wouldn't be able to get pregnant. That bothered me. That's why they told me not to go on the injections and that's why I use pills. **(14)**

They showed us lots of things... the injection they give - that takes away your periods. For some women it agrees with their system - they can get pregnant as soon as they quit. For others who it doesn't agree with, they won't be able to get pregnant again. **(16)**

It is possible that clients misinterpreted what their providers had told them. Our observations of counseling sessions did not document such misinformation however, in our interviews with providers, 2 did report concern that use of family planning methods could leave women infertile. Here is what one of them had to say:

[It used to be that] we didn't give the injectable to a woman unless she had at least 2 children in case it turned out that she couldn't have more children... so we had it in the back of our mind that the injections could put an end to your fertility. As for me, I'm still not convinced [that it doesn't cause infertility].

For several (7) of the women interviewed, their concern about possible threat to fertility long-term was the *key* factor leading them to discontinue:

My husband and I don't use anything now because I found out that if you take the injections too long, you won't be able to get pregnant. I know a woman who was on the injections and stopped to have a baby but she tried for more than a year and had to use [traditional] Ghanaian medicines before she could get pregnant. That really made me worried; that's why I quit. **(11)**

And from the Lomé round-table with current and former users:

My husband kept telling me about how hard it would be getting pregnant after being on the injections. ...I thought it would be best just to quit.

For others, this fear was *one of several* factors influencing them to discontinue. Even for women not quitting because of such concerns, for many there was confusion between

information given to them by providers about *delayed return to fertility after quitting* and *permanent sterility*.

Now that I have this baby, I am afraid that if I started on the injection again it could take a very long time to get pregnant or I may even become sterile. That's why I quit. **(29)**

Two *continuing users* were troubled because of reports from peers that modern family planning would imperil their fertility. One had this to say:

I'm still taking my injections regularly. But, you know, hearing what people say gets us worried. I wonder if I keep on getting the injections whether it will make me sterile. Because of these rumors, my husband went to see the midwife to tell her about his concerns. **(33)**

Another continuing user was inclined to believe that the method could leave her sterile, but since she already had as many children as she wanted this did not bother her.

Some people say that the injections will make you sterile; you won't be able to have children anymore. Others say you'll still be able to. As far as I'm concerned, it doesn't matter to me if I can't have any more. **(10)**

Continuing users who hear from peers that contraceptives could harm them have to weigh the credibility of their peers' assertions against those of their service providers.

Women say that the injections give them sicknesses; they don't have their periods anymore. But the midwives told us that if we lost our periods, there's nothing to worry about. Still, my friends keep saying that the injections are no good and that they shouldn't be used. **(17)**

Similarly, users report having to weigh reports from their peers against their own experience.

My friends say it makes them sick, that's why some have quit. Me, to tell you the truth, I never had any problem with it. **(32)**

Often expressed by current and former users was that some could use such methods with no ill effects, but that if the product was not right for one's system, one could be harmed.

From what they told us about the injections, everyone's system reacts differently, positively or negatively. It suits some women and doesn't suit others. When we were on the injections I used to ask the question and some of the women said they were fine on the injection. Others said it didn't suit them: they didn't have their periods anymore. Some said the injections gave them sicknesses and that they couldn't keep taking the injections. That's why we quit. **(27)**

An explanation given by one male focus-group participant for why such methods could be harmful to Togolese women was that, "these products are made for Europeans and now they bring them here for African women, ... that can cause problems."

Men also shared this fear, as was evident from several comments during focus group interviews:

Women who are on the injections for a long time, when they quit and try to get pregnant aren't able to; they stay sterile. You wanted to have an easy life, but now you end up having to go to the traditional practitioners to try to have children. The needles are no good.

3.4. Family Planning Services

Issues related to services contributed to the decision to quit for at least half of the former users interviewed. This was clearly more common in the urban sample (drawn from a high volume clinic). In other cases, while specific complaints about services were not made, providers did not provide sufficient assistance or advice to women bothered by side-effects or concerns about long-term safety on their method and these women quit into in-need status.



3.4.1. Client-Provider Interaction

Affective/Social Dimensions of CPI

During observations of consultations, providers were consistently respectful and attentive. While the presence of an observer undoubtedly had some effect on provider behavior, most clients who were interviewed reported that they felt they were well treated by their providers. However, while this was the most common judgment of the affective dimension of provider performance, many current and former clients interviewed reported other experiences. Among the 23 interviewed who discontinued, 4 reported that bad treatment from a provider was *a* reason or *the* reason for having quit.

One of them had this to say:

If you go somewhere and you are treated badly, maybe it's because you did something wrong. I know I missed my appointment but when I asked her to forgive me she wouldn't - that's why I quit. **(9)**

One dissatisfied former user had this to say about treatment received at the clinic.

Some of them are really mean and they insult lots of the patients.... They use foul language to the point that sometimes some of the patients argue with them. They tell us to come at 6 in the morning, but we sit there waiting until 9 before they start to see us. If you show that you are at all impatient, they insult you... We're just like them, we're human too. They should treat us well and not treat us like servants. We don't know everything, we can get things wrong, so they should be careful what they say. It's out of place for them to say, "open up your mouth for the injection". You should respect a fellow human being, not put her down. **(6)**

Even among *continuing users*, there were reports of rough treatment of clients.

When a sick person or a pregnant woman goes there the provider insults her if her underclothes are torn and she does it with a loud voice so everyone outside can hear. The client goes out all embarrassed and confused... Some get disheartened by such treatment and don't go back anymore to the public clinic but they don't have the money to go to a private clinic. **(3)**

Another relatively satisfied former client explains that in stressful circumstances in the clinic when there is a big backlog, clients can successfully avoid abusive treatment from the provider by not expressing impatience.

When I arrive late and there are lots of people waiting I wonder if I'll get in but I've never ended up going home without being served. If the midwives come out they tell me I'm too late and that I should go home, I don't say anything, I just stay there. But I'm polite and they end up seeing me. If clients make a fuss, they end up going home without being served. If both the midwife and the client get mad, it's not going to work out. One of the 2 has to be patient. **(8)**

Counseling at First Visit

From observation of consultations with new clients and from reports by current and former clients who were interviewed, the general pattern observed for first visits was as follows:

- 1) social introduction (which may elicit a little information on the client);
- 2) give detailed, standardized (i.e. not tailored or individualized) presentation on available methods, often with brief discussion of possible side-effects (in several observed cases, clients were clearly already well-informed about methods, knew what they wanted and were not particularly interested in hearing about them all again - but were required to sit through the full standardized presentation);
- 3) ask the client her choice (with little if any assistance given);
- 4) physical exam;
- 5) present additional information on chosen method (if necessary);
- 6) elicit information to fill in the clinic card (age, address, number of children, medical conditions, etc.). In most cases, this was the only assessment of the client's specific circumstances.



On initial visit, providers give little attention to assessment, instead using a standardized approach to providing information about methods. Providers feel their responsibility has been discharged if they have gone through each method, listing advantages, disadvantages, etc. As one provider explained,

When there are methods to present, you have to present them. It's not going to tire them out and most of the time they understand better. They'll ask questions and end up choosing the same method they had in mind when they came. You can't refuse them. But the provider *has done her job*; she has to show all the methods.

Some providers, during their explanation of the methods, go into considerable detail describing anatomy, physiology, and mechanisms of action related to each of the different methods. However, the study did not document any discussion of normal menstruation and the mechanism for menstrual changes related to method use.

In less than half of the observed sessions with new clients did they receive their choice of method at the first visit. In most cases they were asked to return at a later date, either for a pregnancy test or when menstruating. Generally they were offered condoms or spermicide as a temporary method.

3.4.2. Management of Side-Effects & Other Symptoms Attributed to the Method

In all observed first visits there was at least some discussion of possible side-effects. Most of the women interviewed reported having been given some information on possible side-effects at their visit (although a number insisted they had received no such information).

As already described, many users do end up experiencing either: 1) predictable changes in menstrual pattern, 2) side-effects or complications likely directly related to the method, or 3) other symptoms which they may suspect are caused by the method, but which may or may not be related. Sorting out what is going on, providing appropriate counseling and, if necessary, providing medical management clearly represent important professional challenges to providers.

Many current and former users reported visiting the clinic and expressing concerns over loss of periods or menstrual irregularity. Most often, they raised the issue because they were concerned about their possible *significance* rather than because the menstrual changes themselves were intolerable. Providers' usual response was, "it is normal, it's not a sickness, it's just an effect of the product." In some cases, this was reassurance enough and users went home with their fears relieved. In other cases, however, this reassurance was not sufficient. Whatever the provider said, the conviction remained that it cannot be normal to lose one's periods. In several observed or reported cases, it was clear that the provider was attentive, gave the client the opportunity to express the difficulties she was experiencing, and responded in a helpful way. In other cases however clients' concerns were not elicited in any detail or they were dismissed.

Most clients who gained weight while on a hormonal method were either indifferent to the weight gain or considered it a sign that the method suits them. However, some were disturbed by weight gain. One pill-user who was on the point of quitting at the time she was interviewed reported the following experience at her last clinic visit.

I told the midwife I was putting on too much weight... She answered, saying that it's just an effect of the product, the hormone. It's normal that you put on weight. I asked her what I could do about it. She said, 'just eat less.' I told her that generally I don't eat much as it is. She answered by asking if I would prefer to get pregnant. I said to myself, this isn't the kind of answer I was expecting. So, I have to get fat if I don't want to get pregnant? As if there were no other options to suggest. **(20)**

No options were given. She reported to the interviewer that she intends to switch to the rhythm method although she has not been counseled by her provider on how to use this method reliably. Indeed fertility awareness and other "natural" methods were rarely discussed by providers (and when they were mentioned were usually discounted as unreliable). This woman's experience was fairly typical of those discontinuing after encountering unacceptable side-effects. Most, even if they did go to their providers, still saw few options. It came down to accepting the side-effect or going off modern family planning altogether. Typical is the following.

I figured that if the injections didn't work well for me, it would be the same for the pills. I didn't want to repeat the same experience. I had chosen the injections, but when they didn't work out for me, I just quit. **(27)**

One injectable user went to clinic because of bothersome menstrual bleeding after several months of amenorrhea. She reported:

Client: They told us that if we had those signs to come back to the clinic. So when I wasn't feeling well I went to see them and they told me that it was nothing, that it must be blood from old periods that hadn't come out that was giving me problems. It's the old stagnant blood from old periods that was coming out now.

Interviewer: Did the midwives prescribe anything for the side-effects?

Client: No, they didn't prescribe anything. They said it was just bad stagnant blood coming out, so they didn't prescribe anything. **(6)**

Unsatisfied with the response, this client quit and did not return.

Several former clients reported experiencing a variety of symptoms likely not directly method-related while on Noristerat[®] (including palpitations, frequent illnesses, various aches and pains), attributing them to the method and complaining to the provider. The next passage is from a client who was initially inclined to accept her provider's view that her symptoms were not related to the method, largely because she was so motivated to avoid a pregnancy, but ultimately was unconvinced.

Once, I went to the clinic to tell the midwife about the muscle pains. She told me it was probably caused by something else; maybe an illness that I had before I started on the injections or maybe from the work I'm doing. At that time, I needed to avoid getting pregnant, otherwise there would have been problems. That's why even though I had those pains, I kept getting the injections. But now the pains have gotten so bad I can't stand it, that's why I quit. (20)

Much depends on how comfortable the client is with the provider. While this client *did* feel free to ask about what she assumed were side-effects and received a sympathetic if ultimately unconvincing response, others reported that they were afraid of the reaction they would get from providers if they complained about problems they were having while on the method.

When we go to the hospital the midwives need to take time with us, to listen to us, to understand that we come to them because of the difficulties we have. Sometimes they treat us badly: they say that our illnesses aren't due to the injections, we must have had those illnesses before. When you tell them the sicknesses you've been having they don't let you speak. We ask to be treated better than that... When we come to the hospital, take the time to listen to us. Don't cut us off. You need to explain to us how these products work so that we'll know whether or not our sicknesses are from the medications. It's the way you bully us that bothers us; we can't even say anything more about the reason we came to the hospital. (18)

3.4.3. Medical/Procedural Barriers

Eligibility exclusions frequently limited method choice. Age limits were sometimes imposed. Much more common was exclusion on the basis of weight, with Norplant[®] (and sometimes Noristerat[®]) refused to women weighing over 70 kg. In some cases choice was restricted because of *insufficient* weight. In a few cases women were refused contraception because they could not prove to the provider's satisfaction that they had their husbands' consent (which is not required under current law). However, the requirement that most commonly complicated *initiation* of use was that the woman be menstruating or, if not, that she submit to an expensive pregnancy test. In most cases, new clients do submit to the rule. One client interviewed in one of the Lomé clinics reported:

I went into the consultation room expecting to get the injection. But from what they said I realized that I couldn't get the method I wanted. I'm not menstruating right now and they told me I would have to have a pregnancy test; I'll come back for it tomorrow.

For others however, these difficulties are sufficient that they do not return. Another client interviewed at the same clinic reported on the experience of fellow-clients:

There are women who come to the clinic and tell us that they haven't had sex since their last period [but can't get the injection]. Not everyone has the courage and determination to come back.

Providers themselves are aware of this. One had this to say:

On the first visit, for a woman to start a method right away we require that she is menstruating. That can push away some women; we tell them to come back but they don't come back. We've referred a lot of women like that *who never come back* to the clinics.

Medical and procedural barriers also contribute to *discontinuation* by established users. A common situation was a missed appointment for Noristerat[®] injection and even when the client was only a few days later or reported to her provider not having had unprotected intercourse, she would be refused her next injection until she began to menstruate. Presumably most such clients wait for their periods and then do return to clinic, where they

would be checked, as described by 2 women from Lomé (the first, who discontinued for other reasons and the second, who continues to use):

Even if you tell them that you are menstruating they demand to see your pad before they'll agree to give you the injection. **(6)**

Really, I came during my period. She told me to go into the room so that she could check to see if I was really menstruating and that's what she did. **(12)**

But not all come back. Altogether 6 of the women interviewed (including women from both urban and rural settings) reported that such experiences had contributed to their decisions to quit. One had this to say:

I was sick and didn't make it to my appointment for my injection. A week later when I went to the hospital, they told me it was too late and that I would have to go home and wait for my period before coming back. **(7)**

This woman waited several months and at the time of the interview described symptoms suggesting that she now has an unwanted pregnancy. In other cases, women were told that since they had missed an appointment they would need to start the whole process over, including intake assessment (and fee), new card, full physical exam, and expensive pregnancy test. Not surprisingly, some clients interpreted this as a form of punishment and dropped the service altogether. The following 3 cases are typical:

Even if we clients tell the midwives that we had our periods and we give the dates, they don't believe us. We know we haven't had sex during this period, but they don't believe us and insist on us going through the procedure for new clients. We have to pay the fee for a first visit. That bothers us. **(37)**

She told me that she couldn't give me the injection because she couldn't be sure I wasn't pregnant. I told her that I'm not pregnant, my husband isn't there, but she insisted. I asked her forgiveness [for missing the appointment], but she wouldn't. So I went and took back the coupon I'd paid for, went home angry and decided not to go back for more injections.... It really disheartened me, because when she told me to come back during my period that means she would do the vaginal exam again. That's why I don't want to go back. **(9)**

They gave me an appointment for the 16th but as it turned out I couldn't come that day; instead I came in on the 18th. She refused to give me the injection because she said she didn't know whether or not I'd had sex with my husband since my missed appointment. I told her that I hadn't but they still refused because they said that I could end up pregnant and then say that it was from a failure of the method. So I was to come back while menstruating or, if my period took too long in coming, I could do a pregnancy test. That would cost me 3000CFA. **(16)**

3.4.4. Waiting time

For 15 clients for whom patient-flow analyses were done, waiting time varied from 6 minutes to 2 ½ hours. The study team did one-day observations in 6 sites (5 study clinics and 1 pilot clinic); the working day began with staff meetings in 2 of them. One of the staff meetings continued until 10:30 a.m.. For that clinic, the clients arriving earliest waited a full 3 ½ hours to be seen. In 2 sites, clients were observed leaving without having been served, clearly dissatisfied. Waiting time was a source of frustration for many women

* approximately \$6.

particularly in high-volume urban clinics. Ten of the 23 women interviewed in their homes in Lomé expressed frustration over waiting time.

While excessively long waiting time annoys clients, many will put up with it regardless and keep coming back. In the following passage, a new client interviewed in one of the Lomé clinics reports considerable difficulties, but because she is strongly motivated to avoid pregnancy, she will come back.

I wanted to be on the injection until I could get enough money to go on Norplant®. But I didn't get to see the cashier because by the time I got there, he was already gone for his afternoon break. So I couldn't even get the injection - I couldn't wait until 2:00 p.m. I have already wasted so much time here; I'll have to come back another day. I will definitely come back. I have 3 children; that's enough.

Another has a similar report.

Client: We wait a long time; some of us get quite angry.

Interviewer: Could that lead you to not come back?

Client: We'll come back (laughs). We get mad, but we stay. We steam and we fidget, but we have to wait if we want to be served. **(3)**

However, other clients *do* quit because of excessive waiting time. Two former users from Lomé reported:

There's the problem of waiting time. When I go there, they're very slow to see me. I end up late for work, that's the main reason why I quit. **(1)**

The providers should try to be quick in serving you but they aren't. They stay in their room and they don't care about us at all. From time to time they call in another client, who'll stay in there a long time before they call someone else, even though there are many of us sitting in rows out in the waiting room. By the time they get around to those still left, it's very late. All this really bothered me; that's why I quit. **(4)**

An otherwise satisfied client had this to say about waiting time, its impact on client and provider tempers, and coping with it all.

What bothers me most when I go to the hospital is that most of the day has to be set aside for the visit. You have to prepare yourself to spend a very long time there. They talk nicely with us when we come into the room. But the providers are mean with those who are in a hurry and impatient. If you are humble and you ask questions nicely, they answer well and you learn things. **(12)**

Another client (interviewed at one of the Lomé clinics) puts her finger on an important reason why providers sometimes behave in an unprofessional way.

Sometimes at the clinic the providers are nice but there are times when they are quite abrupt and nasty. Today... the midwife is alone and I think the work must have been dragging because there are a lot of clients waiting. There's a lack of organization; they need to increase the number of midwives. She is all by herself; she's going to get really tired out.

3.4.5. Costs, Direct and Indirect

Several providers felt that imposing fees has introduced a barrier that discourages some users. One expressed the view that "maybe if it were free, there would be more of them." A small number of clients interviewed found fees for service an obstacle they could not overcome. The following comes from an interview with a rural study participant:

Client: These days life is very hard, we can't feed ourselves. If you find 10CFA, you'll use it to have some corn milled. We don't have any money; it's impossible for us to put together the 200-300CFA it costs for the injection. That's why we stopped; it's not because of side-effects.

Interviewer: Do you find the fees for the injection too high?

Client: No, the fees aren't too high, but if we only have 10CFA for milling the corn and we use it for the injection, what are we going to eat? **(29)**

Another had this to say about the experience of her and her co-wives.

Sometimes we don't have any money, our husband and us. That's how we end up missing appointments. And some of us have ended up getting pregnant by missing appointments. **(37)**

More commonly, transportation costs and lost income were more of a concern than actual fees. As mentioned earlier, high volume and prolonged waiting time can make clients impatient. That is particularly so for those who lose income as they wait. Frayed tempers, in turn, undermine the quality of the relationship between provider and client, which in some cases precipitates a decision to discontinue use of the service. Two study participants had the following to say:

When we go to see the midwives, they don't treat us well. Me for example; I have my children to look after, I sell cooked food, but I end up having to spend all the time that I should be preparing the food, there at the clinic and they don't attend to me. I explain to them that I sell food out in front of the school and that I risk losing customers if I end up losing more time at the clinic. But they don't listen, they're always rough with me. I had enough, so I quit. **(4)**

We get up very early, we need to be at the hospital even before the providers arrive. But then you stay until 11 because you have to get your pills. Often the women who sell at the market get angry and leave, to come back another day. **(14)**

Such financial and time costs also make continued surreptitious use more difficult.

At the dispensary in the village where I live it would be good to have electricity, the necessary equipment and supplies, and providers qualified to use the material. *That way it would be possible for women who want to use without their husbands' knowledge to get served.* But as it is now, they would have to travel to get to a family planning clinic and pay 800CFA to get there and back, and then pay the cost of the method. Also transport is very hard to get. If you don't get back quickly your husband will start asking questions about where you've been. **(25)**

3.4.6. STI/HIV Risk Assessment and Counseling

In *no* observed sessions was there an assessment of a woman's STI/HIV risk or counseling on dual method use (i.e. condom plus another method). Neither was any such *assessment* reported by women interviewed. However, in some cases there was extended teaching on the rationale for condom use. Providers often expressed the assumption that husbands would naturally have other partners.

The following is from an observed counseling session:

The condom prevents pregnancy if it's used properly and also those diseases we can pass to others. If you see one in your husband's pocket you say he's sleeping around. But isn't it better that he doesn't bring diseases home? For the men, wherever they go they try to satisfy their need for that. We can buy condoms for our husbands to carry with them, right? That way we take care of ourselves - you can't get them to stop. If they go out to go somewhere, how will you know?

And similarly:

Provider: This is a condom. When you make love, the liquid ejaculated by the man stays inside and doesn't get into the uterus so there won't be a pregnancy. It protects from sexually transmitted diseases like AIDS...

Client: But I don't sleep around so I can't get AIDS.

Provider: You know your husband - you can buy some and put them in his bag for when he goes out.

More commonly, the only mention of condoms or STI/HIV risk was a passing reference during the presentation of available methods. The following short passage is the *only* reference made to condoms or protection from STI/HIV in an extended counseling session with 2 young single women inquiring about contraception.

There are also other methods like the condom which is very effective against AIDS and venereal diseases.

In this observed session, *all* other methods, including sterilization, were presented in more detail. The 2 young clients were told they would need to return when they were menstruating if they wanted to start on a method. Although in most observed sessions condoms and/or spermicide were offered to women unable to immediately start their chosen method, no such offer was made in this case.

3.4.7. Other Service-Related Findings

Family planning services were available in all sites 5 days a week (although staff able to do IUD or Norplant insertions were not always available) and clinics generally provided such services from 7:30 until 12:00. In certain cases, some family planning services were provided in the afternoon.

In all 6 clinics visited, family planning services are offered within multi-function clinics, but in an area separate from other MCH activities, which provided adequate privacy for consultations. Standards of cleanliness were consistently adequate. No episodes of interruption of water or electrical supply were documented. Access to functioning equipment and supplies was generally adequate although one case was observed of service adversely affected by lack of a functioning scale.

Services were provided by several categories of health professionals including: midwives, nurses, medical assistants, and an obstetrical technician, with assistance provided in some cases by birth attendants. Some, but not all, had received formal family planning training. With few exceptions family planning services were provided by women. Efforts have begun to provide technical supervision (from regional-level staff) to providers on an intermittent basis. Several sites reported technical supervision visits, dealing with infection control issues, within the past 6 months.

A consistent management information system is in place, with standardized clinical records and daily recording of family planning clinical encounters by method and new vs. returned client status. Number discontinuing and lost-to-follow-up are also recorded. This information is compiled monthly and submitted to regional and MOH levels. With the exception of one site, this information was not used for clinic-level performance monitoring. Supplies of family planning commodities are monitored and reordered as needed at the health center level; reports of stock-outs were very uncommon. In all sites visited, supplies of Noristerat[®], IUD, low-dose oral contraceptive pill, spermicide, condoms and Norplant[®] were available.

4. Discussion

This study found that most of the women contacted who were lost to follow-up had discontinued into in-need status. Decisions at the individual level to continue or discontinue were found almost always to be the consequence of the *interaction* of several factors. The most important of these can be grouped into 4 categories: 1) husband opposition, 2) fertility and health concerns, 3) side-effects, and 4) provider issues. The study demonstrated several clusters of cases sharing common factors. The husband's support or opposition always plays some role. For most women discontinuing into in-need status, *both* side-effects *and* fertility and health concerns were involved. It is important to recall that most study participants were injectable users and therefore, almost inevitably, experienced menstrual changes. Beliefs and meaning attributed to these changes were more often the key factor than pain, discomfort or inconvenience.

As is evident in the 1998 Togo DHS and in this study, most men and women recognize the importance of limiting the number of children to the financial means available to support them. Modern family planning is an increasingly acceptable option. But men are less well informed about the details of modern contraceptives, therefore more readily influenced by reports that they are harmful. It is also still common for men to equate contraceptive use with infidelity, so they may oppose contraceptive use even if they are motivated to avoid having more children.

Despite recognition of the need for child-spacing or limiting, couples tend not to talk about these issues. This puts women in an awkward position where the choice seems to be limited to unilateral action or doing nothing. The men interviewed in this study tended to be offended at the idea of women making important decisions (such as initiating contraceptive use) behind their backs, although a number acknowledged that in at least some circumstances it could be justified for a woman to use contraceptives without her husband's knowledge. This in fact is very common, as is apparent in other research done in Togo (Edah 1996). So, many women are prepared to use contraception even when their husbands are opposed. Typically those that do have some financial autonomy. The converse is that those who are entirely financially dependent on their husbands do not feel at liberty to make such unilateral decisions.

Beliefs about the consequences of contraceptive use, *symptoms* experienced while on the method, predictable *physiological effects* of the products, and the *providers role* in providing anticipatory counseling and responding to concerns as they arise are tightly entwined. This complex of issues played a part in most decisions to discontinue.

Modern contraception is still feared by many, understood to lead to sterility or serious health problems. Legalization and government support for family planning are still fairly new in Togo and many practitioners vividly recall earlier policies, which restricted availability of such methods to women who already had several children, the rationale for such policies being a concern that the methods could leave women permanently childless. The capacity to have children is highly valued and, at least in relation to contraceptive use, this capacity is seen to be somewhat fragile and vulnerable. The continued use by some providers of procedures such as vaginal lavage for fertility restoration after quitting contraceptive use reinforces the idea that contraceptive methods at least temporarily damage a woman's reproductive capacity and active efforts are required to reverse these effects.

Menstrual changes associated with IUD and hormonal methods are a problem for many users. However more common than the effects themselves being intolerable is that the symptoms are interpreted as indicating that there are, or could develop, problems of

sterility or serious illness. Because many users believe that to lose one's periods is not natural or normal, they are inclined to attribute such a loss as the cause for any symptoms or health problems they experience while they are amenorrheic. On the positive side, women experiencing weight gain while using a method often interpret this as indicating that the method agrees with their system and has contributed to their becoming more robust and healthy.

The following discussion is organized following Murphy's (1998) concise summary of key aspects of *interaction between providers and clients*, notably:

- 1) Treat the client well
- 2) Provide the client's preferred method
- 3) Individualize
- 4) Aim for dynamic interaction
- 5) Avoid information overload
- 6) Use and provide memory aids
- 7) Key information: effectiveness, side-effects, advantages & disadvantages, how to use, when to return and what to do about side-effects, STI prevention

Providers were courteous with their clients when they were observed, although many of those we interviewed reported circumstances in which clients were treated disrespectfully. This was particularly likely to occur in situations in which there was large client volume, insufficient staff, and long waiting times.

Medical or procedural barriers interfere with clients receiving their preferred choice. They contributed to discontinuation and appeared also to result in loss of new clients before they even started. Most common was the practice of insisting that a woman either *be menstruating or have a pregnancy test done* in order to start a new method. It is of course good practice to determine if a woman is or is not likely to be pregnant and to advise clients to wait if pregnancy is possible. However, providers insisted on menstruation or a pregnancy test even for women who had just discontinued other methods (IUD), who had just completed menstruating, who were still abstinent post-partum, or who reported no sexual intercourse since last normal period. Since the pregnancy test is relatively expensive, most new clients who are not menstruating ended up going home without having started the method they wanted. Both providers and clients reported that many such women don't come back. A similar situation arises for established Noristeral[®] users. Women returning late for their injections frequently were refused their injection, even when they were only a few days late or reported no sexual intercourse since their missed appointment. Several reported such an experience, at least one of whom was likely pregnant by the time she was interviewed. Another category of medical/procedural barrier interfering with client's receiving their preferred method was inappropriate *exclusions by age* or, more often, by *weight*. Heavy women were told they were ineligible for Norplant[®], or in some cases for any hormonal method. In some cases women were told they were ineligible because they weighed too little. Such unnecessary exclusions narrowed the range of options and in several cases resulted in discontinuation into in-need status rather than method switching.

Providers typically spent little time listening or eliciting the client's concerns. With new clients, very little time was spent assessing their particular needs and circumstances. Most of the time was taken up with a standardized presentation on the different methods, not individualized or tailored to the specific client. Since much of the information was irrelevant, not surprisingly women tended to remember very little, even of the parts more important to them. Therefore women are frequently inadequately prepared to interpret or manage predictable side-effects that arise. And since their particular circumstances and

preoccupations were not elicited in any detail and the process of coming to a choice of method tended not to be very interactive, new users typically get off to a shaky start, having perhaps not made the best choice of method in the first place and leaving the clinic without all the necessary information to interpret and manage what symptoms or difficulties in use they may experience.

Was the *key information* provided? Providers generally warned new clients that they could experience menstrual changes, although such information was usually vague and generally downplayed. Women starting on injectables were *not* told that if they use for a year or more they are *likely* to become amenorrheic. When women came to clinic distressed about such changes, they were commonly told, “it’s not a sickness, it’s the effect of the product”. For many women this is adequate reassurance, however for many others it is not. Against the word of the provider comes to bear the full weight of the traditional understanding of menstruation and reproductive function. Not to have periods is not normal unless one is pregnant or beginning menopause. If the blood isn’t coming out, where is it going and what is it doing to the body not to be able to get rid of that old blood? That some providers themselves harbor suspicions that their products can, at least sometimes, cause sterility makes it difficult for them to be fully convincing in their reassurance.

When clients spontaneously volunteer it, providers do learn certain things about their clients’ reproductive goals, about the sexual networks they are part of, about frequency of contact with the partner and about possible *risks of STI/HIV*. However such information is not systematically sought. In most observed sessions with new clients, discussion of condoms and STI risk was one-way (provider-to-client) and very brief. Dual method use was never discussed. No effort was made to determine if the woman’s partner was a member of a high-transmitter group (e.g. long-distance driver) nor were women given information to allow them to make their own assessments of risk of infection as it pertains to choice of method. When women came to clinic with symptoms of a reproductive tract infection, in no case documented was any provision made to treat the partner nor was there any discussion of condom use.

Clearly there are many factors bearing on a woman’s decision to continue using contraception that are beyond the control of providers; attitudes and beliefs in the broader community about contraceptive use, the way husbands and wives communicate and make decisions, the role of peers as sources of information and pressure to conform. But how providers respond to their clients, the kind of relationship they develop with them, how they work with their clients in choosing a method, help them in using it, respond to them when difficulties or worries arise - all these are ways that providers can help their clients use contraception more successfully and ultimately achieve their reproductive intentions safely.

5. Recommendations

This study has looked at influences on decisions to continue or quit contraception. Given what has been learned, how can family planning programs better meet client need? The issues presented below are those arising from study data where there seems the most scope for better supporting women's continued use through family planning services. Specific strategies listed are tentative suggestions on how to address these issues.

Issues

Strategies

1) A Client Focus

- | | |
|---|---|
| <ul style="list-style-type: none">• Instead of insisting “that these are the rules of our clinic and you, as a client, have to accommodate to our ways of delivering services”, the program and clinic services need to accommodate themselves to clients’ needs and preferences.• Providers should be seen by their clients as helpful, available partners who can assist them in dealing with any problems or concerns.• Avoid Long Waiting Times | <ul style="list-style-type: none">• Demonstrate commitment from the top-down to a Client Focus (letter from the minister, clear performance expectations, technical supervision), in order to change expectations and norms of provider behavior at the clinic level.• The IPPF Clients’ Rights orientation should be introduced and championed from the highest levels on down.• In high volume clinics, develop more efficient use of human resources, use of auxiliary staff.• Arrange work so as to start seeing clients at the beginning of the day; leave staff meetings and cleaning to the afternoon (i.e. don’t leave a waiting room full of clients waiting hours while you attend to such tasks). |
|---|---|

2) and Availability Access

Eliminate Inappropriate Medical or Procedural Barriers

- | | |
|--|--|
| <ul style="list-style-type: none">• conforming to WHO guidelines | <ul style="list-style-type: none">• Appropriate protocols and policy documents prepared, disseminated, implemented, evaluated.• For starting a method - replace menstrual/pregnancy test requirement with an assessment of probability of pregnancy by patient history. If the woman reports no unprotected vaginal sex since her last period she should not be required to have a pregnancy test or to delay starting till her next period.• Eliminate inappropriate weight restrictions. For women over 70 kg who want to be on Norplant[®], simply advise them that the failure rate may be slightly higher than for lighter women but still very low.• For women late for Noristerat[®] injection, drop the automatic requirement that they submit to pregnancy test or wait for next period.• Instead:<ul style="list-style-type: none">• If less than 1 week late (2 weeks if amenorrheic), no special precautions are required - simply give the shot.• If more than 1-2 weeks, but little likelihood of pregnancy by history (i.e. no |
|--|--|

unprotected vaginal sex since 1 week after missed date), give shot and advise woman to avoid unprotected sex for next 48 hours. (Tell woman that it is not advised to have the shot if she is pregnant, although there is no evidence that it will harm the fetus)

- If possibility of pregnancy, have client use back-up method till next menses and then give next injection.

Integrate STI/HIV Prevention (and Treatment) More Fully into Family Planning Service Delivery

[although investigation of these issues was not an objective of this study, findings documented scope for improved practice.]

- STI risk assessment (/self-risk assessment) should be incorporated into standard counseling.
- Dual method use should be encouraged for clients at risk
- When clients are treated for STIs, their partners should also be treated

3) Helping Women Start & Successfully Continue FP

Counseling needs to be much more interactive, eliciting client's circumstances, her preferences, her explanatory model for menstruation and fertility and her beliefs about the effectiveness and safety of available methods.

Information given needs to be individualized and she needs to be assisted in coming to a method choice appropriate for her. She should receive enough information but not be swamped with masses of irrelevant detail. She needs to know what to expect when she goes on the method and what to do if she has problems.

- Provide training and ongoing technical supervision on counseling new and returning family planning clients
- use materials like Population Report GATHER guide (Rinehart, Rudy, & Drennan, 1998) (French version in preparation)
- Develop/adapt and implement use of worker aids

Counseling on Menstrual Changes

- Both at 1st visit and on an ongoing basis, women's concerns about menstrual changes (and especially loss of periods) need to be discussed in detail. How they understand physiology and the significance of menstrual changes needs to be respectfully elicited.
- Providers should encourage those considering adopting injectables to imagine themselves amenorrheic or having irregular bleeding and anticipate how they would respond. This may help direct women, for whom such symptoms would be unacceptable, to other method choices.
- Misconceptions need to be explicitly addressed. It is not enough to dismiss a woman's concerns and simply to say, "it's normal; it's just an effect of the product".

- Provide training and ongoing technical supervision on counseling new and returning FP clients
- Use materials like PRIME/INTRAH's "The Menstrual Cycle"(Mtawali, Pina, Angle, & Murphy, 1997) (available in French)

Dealing with Fertility and Health Concerns

- For many women it is not effective just to make, in a standardized presentation, a brief claim that the woman will have no problem conceiving when she quits. Women have specific concerns that need to be addressed individually. It is therefore appropriate as a standard part of counseling new clients to ask what the woman has heard about the possible effects of these products and *what she thinks*. Again, such information has to be respectfully elicited and where there are important misconceptions they need to be directly & respectfully addressed.
- IEC work addressing common misconceptions about negative effects of modern contraceptives needs to take culture seriously, seeking ways to correct misconceptions that successfully bridge between traditional conceptual models and modern biomedical understanding.
- Provide training and ongoing technical supervision on counseling new and returning family planning clients
- Develop/adapt, implement use of worker aids

Equipping Providers to Better Respond Technically on Side-Effect Management

- Providers need a good understanding of the mechanisms of action of methods and management of common side-effects.
 - appropriate technical updates and supervisory visits
-

4) Male Role

- Men need basic information on family planning, addressing factual misconceptions.
 - Deeper issues of male-female power balance are less easily addressed, but those in the family planning sector can partner with other social movements to advance these issues.
 - Develop and implement IEC strategies for outreach to men
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7. Appendices

7.1. Instruments/Interview Guides

Screening Questionnaire Used in the Conduct of the Togo Discontinuation Study (English Translation)

1. How many living children do you have?
2. When was last baby born?
3. How long was that baby exclusively breast-fed?
4. How long after that birth did you remain abstinent?
5. Are you currently pregnant?
6. If currently pregnant:
 - a) were you using a FP method around the time of conception (what method?),
 - b) did you quit with the intention of getting pregnant, or
 - c) other.
7. How soon would you like to get pregnant again?
8. What was the last family planning method you used?
9. Are you using it now?
10. If not, when did you discontinue?
11. What were your reasons for quitting contraceptive use?
 - a) to have a baby
 - b) no sexual contact, therefore no need
 - c) side-effects or concerns about possible long term health or fertility effects
 - d) husband opposed
 - e) other
11. Approximately how long (uninterrupted) did you use contraception?
12. Were you a first-time user or had you had previous experience with FP (if so, what method? How long?)
13. What was your reason for using (limiting, spacing, other)?
14. What is the nature of your relationship with your current partner? (choose one of the following):
 - a) no partner, abstinent
 - b) no regular partner, occasional sexual contact
 - c) non-resident regular partner
 - d) monogamous resident partner
 - e) polygamous resident partner
 - f) regular partner, but away >2 months
 - g) other
14. How old are you?
15. How many years of schooling have you completed?
16. What is your mother tongue?

Interview Guide for In-Depth Interview of Current and Former Users

Starting, Using, and Quitting Contraception (20 minutes)

1. Can you tell me how you came to decide to start using? What were your reasons?
2. What things or people or circumstances (side-effects, husband's opposition, etc.) made continued FP use more difficult? How did you deal with them?
3. Is there anyone in particular who helped you or gave you advice on managing difficulties with family planning (including difficulties in use, side-effect, etc.)? How did they help you?
4. Could you please tell me the story of what led to your quitting contraception?

[probe, encouraging detailed account of the various factors influencing the decision and how the decision came about. For certain of the questions that follow, there may have already been reasonably detailed discussion in the responses to the first set of questions. It is only necessary to specifically address these questions if not already adequately covered.]

Side-effects (10 minutes)

1. When you first went to the clinic and decided to start on this method, what did the health worker tell you about possible side-effects and how to deal with them?
2. If you had side-effects, how did you deal with them?
3. What advice or assistance did you get from the health worker in dealing with side-effects?
4. Was there anything about the side-effects that made you think about quitting? What in particular?
5. From your understanding, what are some of the bad effects that your contraceptive method could cause? What did your health worker tell you about them?

What People Think about Family Planning and How That May Affect You (15 min)

1. Do you think it's OK for people to use family planning? Could it be wrong or bad; if so - in what circumstances?
2. In general how do your friends, neighbors or relatives feel about people using modern contraception (do they approve or disapprove, mixed)?
3. Do you know if any of your friends, neighbors, or relatives use modern contraceptives? Is this something you talk about?
4. How does what friends, neighbors, relatives, or husband feel about contraceptive use influence you? Did it make a difference in your deciding to quit using?
5. Who encouraged or helped you in your contraceptive use and what kind of support did they give?
6. Who discouraged or opposed your contraceptive use?
7. How does your husband feel about modern contraception?
8. Do you talk about contraception with him?
9. Did he know you were using?

Your Experience with the Clinic (20 minutes)

1. What information were you given at your first visit on: how your method works, how to use it, side-effects and how to deal with them, and dangers?
2. When you've had some particular problem or question related to your contraceptive use what opportunities have you had to discuss it with your health worker? [probe for worker responsiveness]
3. How was it decided what method you would use? What were you told about other methods? Was the method you received what you originally wanted?
4. How have you been treated by staff at the clinic? [probe for warmth and respect] How were you treated if you missed an appointment?
5. What arrangements did they make with you at the clinic for follow-up visits?
6. How long did you usually have to wait to be seen at the clinic?
7. What difficulties did you have related to the location and clinic hours?
8. How often were you unable to get your method because they were out-of-stock?
9. What about the clinic service would you like to see improved to make it easier for women to continue using as long as they need contraception?

Interview Guide - Men's Focus Group Interviews

Introduction

Today we are going to talk in general about how decisions are made in the family. Then we will be talking more specifically about the way decisions are made concerning number of children and family planning.

[For each question get opinions from several participants. See if there is or is not a consensus. If not try to obtain a diversity of perspectives. Encourage dialogue *between* participants. The areas related to decision-making can include finances, schooling of children, taking a second wife...Questions below are *not* to be read verbatim, but this indicates the areas of subject matter to be covered.]

Questions

1. In the family, when there are decisions to be made - for what kinds of decisions or in what circumstances is it appropriate for the man to make the decision on his own, without necessarily any involvement by his wife (or wives)?
2. For what kinds of decisions or in what circumstances is it appropriate for the woman to make the decision on her own, without necessarily any involvement by her husband?
3. In what circumstances should decisions be made together with equal contribution from the husband and wife?
4. Between you and your wife, on important questions how do you come to a decision? Who decides what? Does it depend on the kind of decision? For what kinds of decisions should there be discussion?
5. Do you think the way you handle decision-making in your home is pretty typical of other households?

On family size, birth spacing and such questions:

1. What do you think about modern family planning? Is it a good thing?
2. In what circumstances could it be justified to use these methods?
3. Who should make decisions about using family planning? The woman, the man, both? What if they aren't in agreement?
4. If the husband says no, but his wife goes ahead and starts using without telling him, is that OK?
5. If the woman uses modern contraception, could that lead to infidelity?

Other Possible Questions:

6. In what circumstances would it be OK for you to use condoms?
7. What are your hopes for your children's future?

At the end of the interview ask the following questions verbally, getting participants to answer by raising their hands. Then document the number answering by category.

1. Who has used a modern contraceptive method (including condoms) or has a partner who has used a contraceptive method with you?
2. Who is aged: < 25 25-29 30-39 40+
3. What is your occupation [make a list and add up the number per category]
4. How many children do you have? 0, 1, 2, 3, 4+

Clinic Observation Protocol

Role of Principal Investigator:

- interview providers
- administer inventory instrument
- document space layout
- Photo-documentation

Role of Senior Interviewer

- Observation of client consultations ~ 3 hours
- Tape-record if:
 - new client
 - clinic visit for specific problem
 - routine clinic revisit (1 only)
 - client seen in waiting room by junior interviewer
- Complete observation instrument if :
 - new client (1 only)
 - clinic visit for specific problem (1 only)
- Observation notes on client-provider interaction especially information that will not be well captured on tape (non-verbal)
- Document work organization (who does what, when)

Role of Junior Interviewer

- Follow at least 3 client from arrival to departure from the clinic, documenting by detailed written notes (i.e. not taped)
- With each, explain that we are doing a study on women's experiences using family planning and that if she agrees you will come back to speak with her 3 or 4 times during her visit at the clinic.

Determine:

- time of arrival
- reason for the visit
- her expectations (specific service received, information, solve a problem)
- if she currently uses family planning, what method? For how long? What problems has she had?

During the time with the client, also determine

- all the steps she needed to go through (administrative and clinical)
- their approximate duration
- who she saw, and
- to do what?

This documentation should include a time-line. Come back from time to time to see if there have been any new activities. Try to get her assessment of the service she received.

- Was she satisfied ?
- Why does she come here and not somewhere else?

Give each of the women you speak to a little piece of paper (coded A, B, C by order seen) and instruct her that this needs to be given to the senior interviewer when she goes in for her consultation.

Arrange with each of those you speak with to meet again for short de-briefing interview after their consultation. During that interview, address the following issues:

- Ask for a brief summary of what happened.
- (Reviewing the specific expectations that she expressed earlier) to what extent does she feel they were met?
- What aspects of the service was she not entirely satisfied with?
- In what way was her experience today typical or not typical of previous experiences she's had at this clinic?

End by asking her in what ways the service could be improved.

7.2. Case Summaries

Lomé Case Summaries

All of those interviewed in Lomé were Ewé, Mina, Ouatchi or Adja (closely related southern Togo ethnic groups). Most had received between 3 and 7 years of schooling, report periods of post-partum abstinence of less than a year, and have had more than one episode of modern contraceptive use. Exceptions are noted in the individual case-descriptions. Shaded blocks describe women who have discontinued; unshaded refer to continuing users.

Case 1

This 27 year old married mother of one was very much inconvenienced by long *waiting-times*; it put her job in peril. She was on *Noristerat*[®] for about 2 years and experienced *back pain* and *loss of periods* (which *worried* her although she was told when she adopted that she could lose her periods but that this was normal). While on *injectable* she had occasional episodes of prolonged heavy bleeding, controlled by pills given by the provider. She switched to *OCP*, however that didn't solve the waiting time problem and after 2 years on *OCP* she decided she wanted to *switch* back to *Noristerat*[®]. However, she was *refused by her providers*; although she was menstruating (and presumably using FeSO4 dummy pills) the providers insisted that she finish her pills before starting back on *Noristerat*[®] - putting her into a catch-22 (come back when pills finished - but then would not be menstruating therefore ineligible to start). The client also implied that she had been subject to *disrespectful treatment* by providers. To avoid pregnancy, she is currently using *periodic abstinence*, but ineffectively (days 13-19). She wants her next child in about a year.

Case 2

This illiterate 36 year-old married mother of 4 started on modern contraception 6 months ago. She reports significant financial difficulties, making it difficult meeting the needs of the children she already has. She is therefore strongly motivated to continue using, to avoid adding another mouth to feed (indeed she doesn't want any more children). This is supported by her relatively good tolerance of *Noristerat*[®]. She reports that following her first two injections she had periods of prolonged bleeding, but was adequately warned and returned to the clinic where she was prescribed pills which stopped the bleeding. She is *satisfied with clinic service*. On the negative side, her *husband is opposed* to her contraceptive use, although his authority on this question is compromised by his limited financial support to the family. She reports a 2 year period of abstinence after her last birth. Although she is classified as lost-to-follow-up in clinic records, in fact she was just late in returning for her injection, because of a sojourn back in her village. However, given the widely-imposed menstrual requirement, she may have difficulties getting the clinic staff to agree to give her another shot unless she is menstruating.

Case 3

This 36 year-old married mother of 3 has had 9 years of schooling. She was lost to follow-up from the clinic, but like the previous interviewee turns out to be a continuing *injectable* user; evidently she was not long a client and had little to say about why she changed clinics. It sounds like she went to an NGO clinic for an improvement in service quality. While she is in general satisfied with service at her new clinic she reports that her *current provider* is not *attentive*. She also reports having experienced abusive treatment from providers at another public clinic. She invokes *poor service* (including long waiting time)

as a reason why women don't come, or why they drop out and points out that for those who don't have the money to then go to private clinics, they are then out of luck. She reports that her **husband** has **encouraged her contraception use** and that despite not wanting more children - she would acquiesce if he insisted on her stopping. Although she reports that she has experienced occasional periods of prolonged bleeding while on the *injectable*, **side-effects** haven't been a big issue for her. Her family planning use history consists of an uninterrupted period of 7 years on *Noristerat*[®] and prior use of *periodic abstinence*.

Case 4

After 10 years using *Noristerat*[®], this 36 year-old widowed mother of 4 (now with a new partner) is definitely turned off modern contraception and doesn't expect to start again, despite wanting to avoid a pregnancy. For her the key influence is her experience of a **persisting facial palsy** which began while on *Noristerat*[®] and which she attributes to the method (causing "blood to rise to [her] head"). She had been on *Noristerat*[®] for a long time and had experienced amenorrhea and infrequent unpredictable menstrual bleeding. This however did not lead her to consider quitting (she had been warned when she started that she could lose her periods but that this was not an illness). She quit, hoping that by doing so her palsy would resolve. She also had some acupuncture treatments for the palsy but quit because of the expense. Realizing that she was at risk of an unwanted pregnancy she restarted on *Noristerat*[®] - but with her mouth not returning to normal and experiencing foul-smelling menses she quit again. **Other bodily experiences she attributed to the method** included **pelvic pain** and **recurrent** bouts of **malaria**. **Providers** evidently **didn't give her satisfaction** when she consulted them on this. They simply told her that this couldn't have been due to the method, offered no treatment and made no referral. Furthermore she is bitter over what seems to her to be indifferent treatment by providers at other times. She evidently **lost income due to long waiting time**. Also, her **mother** is very much **opposed to contraception**, considering it equivalent to killing babies in the womb, and attributes her daughter's facial palsy to her *Noristerat*[®] use. Finally, the woman's common-law **husband is opposed to contraception use** and she had been **using without his knowledge**. Her preference would be to have no more children although she would be willing to have another one for her current partner if he wants. She is not doing anything in particular to avoid pregnancy right now. She reports a one-year period of abstinence after her last birth.

Case 5

This 32 year-old married woman has 10 years of schooling. She is motivated to avoid pregnancy (because of financial difficulties, although she would like another child over the next 3-5 years) and remains open to using modern contraception, however she has had a bad experience with *Noristerat*[®] (4 months of use) and then *IUD* (<1 month). She explains this by saying that her "blood was too strong". After her first injection she had a protracted episode of bleeding (she reports **not having been warned** by providers **about** possible **side-effects**) which was treated successfully by providers. After her second shot again she had prolonged heavy bleeding and when she returned to the clinic, her providers suggested she switch methods and she was started on *IUD*, but bleeding continued and after 3 weeks she had the *IUD* removed. She expresses fears that treatment of side-effects could cost a great deal and if one cannot afford such treatments, this condition could develop into a serious illness. On quitting the *IUD* she wanted to switch to *Norplant*[®] but her desire was thwarted: **she was refused *Norplant*[®]** (inappropriately) **because of weight**. She is not interested in *OCP*, fearing side-effects. Her **husband** remains **supportive** of FP use. They are now using *periodic abstinence* (ineffectively - days 5-14) and withdrawal.

Case 6

When this 25 year-old mother of 2 first raised the issue of contraception with her husband he refused, so she **started without his knowledge**. She informed him later on and he didn't make problems. Her **mother is also opposed** to contraception: she believes that "it makes you sick". She was on *Noristerat*[®] for about for a little over a year (her first episode of contraceptive use) when she **became amenorrheic** and developed various other symptoms (palpitations, frequent illnesses, and weight loss) which she attributed to the method (at first visit she had been told she could experience amenorrhea and, according to her, providers also told her she could get palpitations and dizziness as side-effects). This continued and after about 2 years of use, she delayed returning to clinic for her shot and developed prolonged heavy menstrual bleeding (which she interpreted as *injectable*-caused illness) and went to see her providers. She reports that they tried to reassure her, explaining that this was **old stagnant blood from previous suppressed periods**. However it continued and she remained alarmed. She was not at all satisfied with the way they dealt with her and gives a detailed account of what she experienced as abusive, dismissive, condescending treatment. And they offered no treatment of her symptoms. She ended up going to an herbalist for treatment of her **menstrual symptoms**, pain and vertigo. Her husband insisted on her quitting because of 1) the expenses they incurred treating what they perceived to be side-effects, and 2) the possibility it could lead to worse. She complied (although with some ambivalence - she too was afraid this could lead to worse problems but reported that she would have preferred to continue). After quitting, it took several months before her menstrual bleeding returned to normal and over that period she was anxious. She now wants to start on *OCP*. Her husband objects, but she intends to start without telling him. In the mean time they are using *periodic abstinence* (doing the calculations more or less correctly). She would prefer not to have another child for another two years or so and talks about the importance of avoiding too closely space births (*kpédévi*), especially given economic hard times.

Case 7 - unintended pregnancy?

This 24 year-old married mother of 2 tells an interesting story of a very close relationship with her father-in-law, beside which her relationship with her husband pales by comparison. She was on *Noristerat*[®] for 6 months (her first episode of modern method use) and reports that she did well on it, eating well and putting on weight. However, she **missed an appointment** due to illness and when she came to clinic a week late was told **she would not get another shot until she menstruated**. She reports no menstruation in over 6 months (beginning *after* she quit) and may well now be pregnant. She remains **motivated to avoid pregnancy** and would like to wait at least another 4 years before the next birth (although she and her husband are not doing anything to prevent pregnancy at present). She is open to return to the clinic to try to restart *Noristerat*[®]. Her husband supports her contraceptive use as do her sisters. She believes that the best method is self-control. She won't use *IUD* as she fears its use can result in deadly consequences.

Case 8

After 1½ years of *Noristerat*[®] use (her first episode of modern method use), this 29 year-old married mother of 1 quit her injections because **friends of her husband** (particularly a health-worker friend) expressed opposition to modern contraception claiming that it **would make her sick** and cause her to become **sterile**. Her husband insisted she quit and she complied. "It's his pocket, so I have to do what he says. I don't do anything on my own. At the beginning he gave his permission; now he refuses." She also reported that she was afraid to go speak with her **providers** about her dilemma for fear they **would insult or nag**

her. She reports having received no *individual* counseling at the time of method adoption although she had attended a family planning health talk at the clinic (the details of which she remembers pretty well - including the information that *Noristerat*[®] can cause amenorrhea, but that this is normal and the method doesn't cause sterility). Nevertheless, while on the method she was somewhat concerned about having lost her periods and mentioned it at each clinic visit. She is relatively satisfied with the service but notes that to be well treated one needs to go well dressed. She also reports that *providers insult clients* but it is very often in response to insulting comments from the clients themselves. This client is not using any form of birth control and is resigned to getting pregnant. However, she remains *very motivated to avoid pregnancy* and intends to start modern contraception again after her next pregnancy. If she has a son, she doesn't want any more children after that.

Case 9 - ↓'d need

This 47 year-old mother of 5 has a sad tale of *abusive treatment from her husband*, and although they live apart he remains in the picture. She was on *injectable* for 4 months (her 1st episode of use), but because he only comes around from time to time she doesn't see the point of remaining on contraception (indeed, she said she understood that it was dangerous to continue on *injectables* if one was not having intercourse, however a health worker friend assured her this wasn't so). On the other hand, the last 2 (unwanted) pregnancies occurred due to his occasional visits and she remains very motivated to avoid another pregnancy. She says she doesn't want more children. She is also *concerned about long-term negative health and fertility effects* (and at one point gives this as the reason for quitting). She reports telling a younger woman that she shouldn't be on *injectable* until she's already had quite a few children. Otherwise she risks sterility before having achieved her desired family size. She also believes that the *IUD* can cause sterility but that *OCP* is safe for such low-parity women. Peers have told her that the *injectable* causes foot pain, back pain and prolonged periods. While on *Noristerat*[®] she had irregular periods, sometimes up to 10 days long and with intervals from two weeks to two months. However she reports this was *not* her reason for quitting. She was very much put off when she *was refused service because of being several weeks late* for her shot. She *felt badly treated* and gives this as the reason for not returning. The provider didn't accept her report that she'd had no sexual contact. A particular preoccupation of this woman is her dislike of vaginal exams - this makes restarting *Noristerat*[®] so unappealing to her (the procedure involves doing a vaginal exam).

Case 10 - pregnant

This illiterate 40 year-old mother of 3 adopted *Noristerat*[®] (as her 1st episode of modern method use) and used it for 3 years despite *believing it could leave her sterile* and despite her *husband's opposition*. He is also convinced, based on what he's heard people say, that *Noristerat*[®] causes sterility. But she gets *little support from him* and doesn't want more children and, because he provides so little financial support, she didn't feel compelled to submit to his wishes on this matter and became a *covert user*.

While on *Noristerat*[®] she became amenorrheic (she was warned at the time of adoption that this could happen but was entirely benign) and developed *various aches and pains* which she *attributed to the method*. Reporting on these to her providers, she was dissatisfied when they discounted her reports of pain as non-method related. She attached particular significance to her menstrual blood being *black* - understanding that it was *because* it was *black* that she wasn't putting on weight, was frequently ill and experienced severe generalized pain. She had to sell her jewelry and other treasured belongings and spent significant amounts of money on treatments, herbal and "allopathic", fearing that

otherwise she could die. She reports that because of her illness she has not been able to work. Others around her (including her sister, who has had difficulty conceiving after an episode of *injectable* use) reinforced the idea that she was experiencing method-related health problems and **could end up sterile**. One of her providers told her that if she wanted to quit and try to get pregnant she could prescribe fertility-restoring treatments. She was motivated to avoid pregnancy both because her **husband doesn't provide adequate support** and because she tolerates pregnancy poorly (also she is now 40). Nevertheless, because of her symptoms, she quit using (to “get her blood back to normal”), continued various herbal treatments, and (thinking she was still protected, in part because her menses, while back to normal timing, were still black) promptly became pregnant. She reports a 2 year period of abstinence after her previous pregnancy. She is generally **satisfied with the service**.

Case 11

This 32 year-old woman has 3 children. Her **husband provides little support** (and is unfaithful), so she has a financial incentive not to have more children. She is also motivated to avoid pregnancy because she tolerates it poorly. Due to abuse from in-laws with whom she was living, she has now moved out into rented accommodation to which her husband comes visiting from time to time. She has been a **covert user**. She reports using *OCP* for about a year, but quit because she couldn't reliably remember to take it. She then started *Noristerat*[®] and continued on it for 6 months but also found she tended to forget her appointments and **worried about getting in her providers' bad-books** (they've been angry with her before when she missed return dates). What she reported having led to her quit however was **back pain** she experienced after her last injection (she had had 3 shots). She reports having been told when she started the method that she might have side-effects including back-pain or weight gain, but that they wouldn't turn into an illness. Later in the interview however she indicated that in fact she **quit because of concerns that prolonged Noristerat[®] use would render her sterile**. She mentions a friend who waited more than a year after quitting without conceiving; only after taking various Ghanaian (herbal) products did she succeed in getting pregnant. Also, she believes that the back pain developed *because* the *injectable* caused her to lose her periods, i.e. caused by the method, mediated through its amenorrheic effect. She thinks she would like another child, perhaps in about 3 years. She is open to returning to contraceptive use, but wants *Norplant*[®] next time. At this point she reports her periods are still not back to normal.

Case 12 (switcher)

This 28 year-old mother of 3 is in a polygamous union. When she first went to the FP clinic, she mentioned to the providers rumors she heard about methods causing sterility but they categorically insisted that these methods do not have such effects. She used the *IUD* for a year and a half, but developed **menstrual irregularities**, and returned to clinic to have it removed and switch to another method. However, she reports that her providers didn't want to remove it initially and told her she couldn't switch directly to another method. She succeeded, nevertheless, in switched to *OCP* and remained on it for 5 months. She ended up quitting because she wasn't sexually active for a period of time, and when her husband returned they started using *condoms*. She is **motivated to avoid pregnancy** because of attention needed by a sickly older child (although she would like another child within the next 2 years). She tolerated *OCP* well and is confident that it won't cause her any harm. However, she reports that it isn't good for women who haven't already had children to use such methods because they could be left sterile and childless. She is dissatisfied with the **waiting time**.

Case 13

This illiterate 40 year-old married woman has 6 children including one with sickle-cell disease. She doesn't want any more children and went on *IUD*, as recommended by her provider (she didn't want to put on weight). She was on it for about 2 years and reported having lost her periods. When she first went to clinic she was told not to worry about it but on a return visit they did a **pregnancy test** which came up positive - this very much **upset her**. This was followed by vaginal bleeding which the midwives treated with a "**lavage vaginal**" and at this point they told her they'd been mistaken - that she hadn't been pregnant after all; it was only an accumulation of blood. [miscarriage? molar pregnancy?] This left her bewildered and dissatisfied with the service. She was then put on *Noristerat*[®] but had **muscle pains, hot flushes and menstrual changes** (her periods "were not as [she] would want them") and quit after her second injection. She was not comfortable going back, feeling they **weren't patient** with her. She attributed to them a **disrespectful** attitude because she is illiterate. Her husband is currently out of the country (in the US) so she is not immediately in need. He wants her to be on a method but she insists - no, God will put a stop to her child-bearing when he is ready. It seems that the key reason for quitting and not going back was the **traumatic experience of the pregnancy scare**.

Case 14

This 32 year-old married mother of 1 has had 9 years of schooling. She was recruited through the maternity but then **inappropriately denied her first choice** (*injectable*) on the grounds that she was too old and on quitting she could have difficulties having another child. She used *OCP* for 2 years and didn't have any symptoms except that her menses were shorter. However she quit because her **husband** heard on the radio that one is supposed to have blood tests before starting on *OCP* and he then **insisted she quit** (for **fear of infertility**). She didn't stop however and when he found out he got angry and she quit. (Her 2 years on *OCP* were preceded by 2 years using *condoms*.) She reports that after quitting *OCP*, because she didn't immediately resume normal cycling, she went first to the FP clinic but reports she was **treated badly**. She then went to see an MD who did an ultrasound and prescribed lutenyl. Her period resumed the day before the interview. She reports generally being unhappy with the quality of service at the clinic, feeling she was **mistreated** and that **waiting time was excessive**. Nevertheless she says she's open to going back once her periods are back to normal. At this point she is resigned to getting pregnant. Although she hears from others that these methods can cause infertility, she is more inclined to believe the health workers, who reassure her that the methods are safe.

Case 15

This 33 year-old mother of 3 (in a polygamous union) is a *Noristerat*[®] user (when presented the methods, she wasn't interested in the *IUD* because she'd heard it can make the uterus swell up). She took the initiative to start contraception, but has her **husband's support**. She would like to avoid another birth for the next 5 years. She has now been on the injections for about 2 years and had no previous experience with modern contraceptives. She was initially delayed in starting by the **menstruation requirement**. She has had prolonged stretches of time without menses, and when she does have bleeding it typically lasts longer than a normal period, however this hasn't been particularly distressing to her. She notes the **long waiting time** but isn't personally seriously inconvenienced by it. Likewise, she acknowledges that sometimes **providers are rough** in their behavior but that she sees this as just happening in circumstances where it is justified, e.g. when they have to repeat themselves. She is fairly **satisfied with the service**.

Case 16

This 28 year-old married mother of 3 has had a bit of a rough ride. She wants to avoid pregnancy for at least another 5 years and initiated use at her husband's prompting. She adopted the *IUD* and had it in for only 3 months. She had heavier bleeding and spotting, which she didn't like but quit largely because of *non-method related symptoms* (breast pain, weight loss) which she *attributed to the IUD*. She then went on *Noristerat*[®] and continued for about a year. Peers had warned her it would leave her sterile (drawing attention to her loss of periods) but she wasn't convinced; indeed she has recommended modern FP to neighbors. Her responses on this question were somewhat ambiguous - at one point she reported understanding that her providers had told her there was some *risk of sterility*, but later said that in fact what they had told her was that it could take a long time after quitting before one could conceive. She put on weight on *injectable*, was pleased with the effect, and remained amenorrheic for most of that time. Understanding that if she quit she would remain protected for some period of time afterwards and indeed that it could be necessary to take various herbal treatments to restore her fertility, after a year of use she quit and her menses promptly returned (she noted that color of the blood normalized over 3 cycles). Three months after quitting she became pregnant. Several months post-partum, when she tried to restart she was initially *refused because her provider didn't believe she had her husband's consent*; then she was *refused because she was 2 days late for her appointment* and the provider didn't believe that she hadn't had sex with her husband since her last period. She was told either to take a pregnancy test (3000CFA) *or return when she was menstruating*. She received spermicide from the clinic and she and her husband used it but when it ran out, to save the expense of a long trip to the clinic for more he bought saccharine for her to take after intercourse (it is sold in the market as a contraceptive). She generally feels well treated but is bothered by *long waiting time*.

Case 17

This illiterate 37 year-old mother of 4 has been on *Noristerat*[®] for a year. Previously she had been on a once-monthly *injectable* for 3 years, missed an appointment and became pregnant. At this point, she would like to avoid another birth for about another 3 years. On *Noristerat*[®] she lost her periods, had *headaches, diverse pains, flushing and chills* that she *attributes to the method*. She reported these to her provider, was prescribed medication (which she ended up not getting), her periods "came back a bit" and her side-effects spontaneously resolved. Various *peers counsel her that Noristerat*[®] *will do her harm* but she remains *motivated to avoid pregnancy* and therefore to continue using. Like some other otherwise-satisfied *Noristerat*[®] users, she advises peers that if they don't already have at least one or two children, they shouldn't use this method (suggesting that she feels there is some risk of sterility). She makes an interesting point - if one gets side-effects from medications from the clinic, one can go to them for help; on the other hand if one gets products from the herbalist and runs into problems, one cannot seek out care from the clinic [sees providers as resource?]. She also has some *concerns that using for too long a period of time may give serious health problems* but *trusts* that her service-providers will advise her appropriately if at some point she should change methods. (Peers have insisted that the method takes away periods, "makes your vessels rigid", causes arthritis, and makes you sick, whereas providers have told her that losing her periods won't cause her problems). She's also heard that *IUD*'s can give constant pelvic pain.

Case 18

This 33 year-old mother of 2 is in sad circumstances. Evidently her husband engaged in various illicit sexual activities including raping his sister-in-law and sexually molesting a young girl in the family. As a consequence, the woman's family insisted that she leave him.

However her children remain with him and he doesn't let her see them. When she first had the *IUD* inserted (*secretly adopting after her husband refused*), she had it replaced a month later because it caused her much suffering when it “went into her uterus”. The new *IUD* was expelled within a month and she decided that her system wasn't suited to *IUDs*. Some time later she started on *Noristerat*[®], again *without her husband's knowledge*. She reports that he never suspected her of hidden FP use. This episode of use lasted about 3 years. While using she became amenorrheic but reports not having been disturbed about this. She also put on weight but took this as a sign that it was good for her. However she eventually developed diverse *pains* (knees, ankles, back) and weakness that she *interpreted as being the effects of having her lost periods*. She reports they were significant enough to prevent her from going out peddling her wares. She ended up quitting but about 2 years later, fearing pregnancy, she restarted and continued for about a year. By this time the crisis with her husband had developed and she ended up leaving and moving in with her parents. So again she *quit*, this time *because of temporarily decreased need* and because the same symptoms persisted (and do so even now, 2 months after quitting). She feels the method has left her sickly. On reporting her pains to her provider, she was told they were unlikely to be due the method (although she remains unconvinced) but since she was sexually active at the time and determined not to get pregnant, she continued despite these symptoms. Later, as the pains became more bothersome and she had less need for protection, she quit.

Since then, however, she has become an informal second wife to an older man, this at the prompting of her parents who insist that she not remain single. She is however unhappy about this situation and doesn't want more children. She is particularly preoccupied about the children she already has and wants them back. Now that she is again sexually active she acknowledges the need for contraception and says she will likely start again (despite some concerns about rumors of adverse effects - peers have told her such use could even lead to death). She gives an eloquent account of the reasons *FOR* using contraception, despite not currently using. In her circumstances she refers to the providers in a way that suggests her expectation that they will be able to help her find a solution. However she says that *providers need to be better listeners* particularly when clients come with problems with their methods, and to explain how the methods work so that clients will know if symptoms they experience are or are not caused by method use. She reports *sometimes-abusive treatment* from providers and feels she was *not sympathetically received* when she came to providers with problems. Her own mother had 10 children and was sick for the last 4-5 years of her life; this motivates her to avoid further pregnancies of her own.

Case 19

This illiterate 41 year-old mother of 3 gives a story full of suffering. Uneducated and naive, she started out as an “outside wife” of a man who led her to believe that he had only one other wife. When several years later she moved in, she found that there were 4 others (plus assorted short-term mistresses elsewhere) and they did not welcome her arrival. She was beaten by some of the children of older wives. (Her husband has over 50 children!) She did well with her own business and started building her own house without his knowledge. One of her co-wives died of AIDS. Her husband lost his job and although at one point he built a modest house for her, now he provides insufficient support. Her own business continued to go well, which she attributes in part to the good luck that her abusive husband brings her. However, the family's finances have deteriorated. She is motivated not to have any more children (and has aborted 2 pregnancies). She also suffers from *chronic low-abdominal/pelvic pain* - [endometriosis/PID/psycho-somatic?] which began since she's

been with him but before she started on *Noristerat*[®] (*without her husband's knowledge*). She attributes it not to the method but to sorcery, but *believes that being on Noristerat*[®] *provoked an exacerbation of this problem* and that her chronic health problem has to be resolved before she can resume contraception. While on the method, she had *irregular and sometimes heavy menstrual bleeding* which she links both with her pre-existing illness and with method use. Since quitting (after 6 months of use) she has been using an herbal preparation (also without her husband's knowledge) believing that it will prevent pregnancy. She did during this period return to clinic wanting to start another method. Although she had heard from peers and parents that *IUDs* are bad (because "they could penetrate into your uterus"), she decided that was what she wanted. When examined however, she reports the provider found she had some kind of pathology in the uterus [or cervix?] and sent her home with a treatment. When she returned to clinic there had been no change and she was referred to a physician, however her husband refused her permission to be seen by a male service provider and there has been no subsequent contact with the clinic.

Case 20

This articulate 30 year-old married mother of 2 has 11 years of schooling. She would like to avoid another pregnancy for at least 5 years. She is generally *satisfied with provider* professionalism, but has had 2 episodes of *OCP* use both of which have resulted in *unacceptable weight gain*, the first lasting 1½ years (she is afraid of adverse effects from the other methods). She now is *about to quit* after 2 more years of use. She was quite *unsatisfied with the provider's response* when she raised the problem of weight gain at her last visit. The provider's solution amounted to, "eat less, or quit and have babies". She now plans to use *periodic abstinence* (as she has previously), although has received no instruction from her providers on its reliable practice.

Case 21

This 27 year-old single mother of 2 has 11 years of schooling and her current episode of *IUD* use began 4 months ago. She doesn't want any more children. She started using FP as an apprentice, after having given birth to one child - and did so to allow her to complete training not hindered by the care of too many children. She knew the provider, a good friend of her mother. After a brief experience on *OCP* (<1 month) and experiencing *excessive bleeding*, she quit and, according to her, went about 5 months with no menses and then had an *IUD* inserted and has had little problem with it. Her first interval of *IUD* use lasted 4 years. She reports having received counseling about the importance of keeping very clean as long as she is on the *IUD*. She is an *enthusiastic supporter of the providers* and their methods and has recruited a number of her peers to become contraceptive users. Nevertheless, she is *inconvenienced by long waiting times at the clinic*.

Case 22

This 36 year-old mother of 3 was little inclined to talk and gives a sad story. She has had a series of bad experiences with men: her 2nd man married her, she gave birth to their child, and he then promptly abandoned her (the child now lives with him). She later married a male nurse; initially he treated her well but then without warning he took on another wife and moved in with her. He, in effect, abandoned our interviewee but continues to provide some support for their daughter. She first used *Noristerat*[®] 7 years ago (for a period of 6 months) and restarted 2 months ago, reporting that she needs sexual intimacy but is not in a position where it makes sense to have another child right now. Her initial choice of *Noristerat*[®] was due in part because she "lacks blood in her body" and is often tired and thought this the most appropriate method (she is also afraid of *IUDs*). For her, having use

of contraception is a big help preventing, as it does, further exacerbating her suffering. She reports getting *hot flushes* after her *Noristerat*[®] shots. Earlier she had experienced hair loss. She was unsure whether or not this was due to method use and eventually it resolved.

Case 23

This illiterate married 35 year-old woman is a grand-multipar (G11) and grandmother of 4. She had a brief experience using the *IUD*. On that occasion she *started without her husband's knowledge*. When he found out he was not pleased, however she reports that her reason for having it removed was not because of him but *because of side-effects*, notably *pelvic pain and increased bleeding* (which disgusted her). Nevertheless she abandoned into in-need status rather than switching methods. Her last birth was very difficult and painful; this *motivated* her to seek the means of *avoiding any future pregnancies*. Perhaps a more important motivation was that her *husband doesn't adequately provide* for her and the children. She says that if he did, she'd be content to keep having babies. She started on *Noristerat*[®], but after about 3 years on the method, she missed an appointment because she was out of town caring for her sick father. On return to the clinic, they *refused to give her the shot*, insisting that she return when she has a period. She then went to another health center to try to restart and was accepted. She reports *positive side-effects* - she feels younger, vibrant, more attractive. She has *lost her periods but is not disturbed by this*; indeed she *finds it convenient* (note however that she has no desire for future pregnancies). She reports being well treated by providers at the clinic. She is quite an enthusiast of modern contraception and talks eloquently of how liberating it has been for her.

Yoto Case Summaries

All but 2 of the women interviewed in Yoto were Ouatchi. A little less than half have had some schooling (but none more than 5 years). Most report periods of post-partum abstinence of less than a year and most have had just 1 episode of modern contraceptive use. Exceptions are noted in the individual case-descriptions.

Case 24 (not in-need)

This 28 year-old mother of 1 was on her own with one child for a number of years because her husband was away working in Nigeria. Perhaps this accounts for the longer-than-average period of 12 months of abstinence she reports after her last birth. She has worked recently as a domestic for an Indian family and on his return her *husband insisted that she go on contraception* so as not to imperil her employment by pregnancy. While on *injectable* she was amenorrhic but didn't report that as disturbing to her; she had been warned in advance by her provider. Her provider also told her that her periods would start again when quit. She quit about a year ago, and indeed they promptly resumed. She reports her *mother-in-law telling her that because she was on Noristerat[®] she wouldn't be able to get pregnant* in the future. She taunted her, telling her that she was using contraception because she had some money and didn't want to make children for her husband anymore. To prove her mother-in-law wrong, she quit *Noristerat*[®] (after 10 months of use), intending to get pregnant. In the mean time, her husband had been chasing young women and 3 months later brought home a new girlfriend, the recently impregnated daughter of a friend. The interviewee objected, insisting that she leave. The girl left and the husband left with her. Since quitting she still feels her periods are not yet entirely normal (the quantity is less than it used to be) and she's afraid this is some kind of sickness. The interviewee *reported favorably on the care she received from the FP service*, however she was not happy with other services at the hospital.

Case 25

(Interview conducted at the clinic.) She is a relatively prosperous 34 year-old Ewé woman living in predominantly Ouatchi Yoto prefecture. She has 7 children (and doesn't want any more) and for the past 6 months, with her **husband's support**, she has been using *Norplant*[®]. She reports amenorrhea and slight weight gain, neither of which disturb her. She is also a keen observer of the local scene, where she sees women really struggling and although she sees benefit to many if they were to adopt modern contraception, she sees difficult obstacles. There are still pro-natalist values, husbands aren't open to it, getting the method generally means having to go to a clinic in another community, increasing cost and likelihood of husband discovering. She is **satisfied with the service**.

Case 26

This interesting woman is 53, has had 10 children and lives separately from her husband. She's an important opinion leader in her community. She used *Noristerat*[®] without problems for almost 3 years but then developed **symptoms she attributed to the method** (nipple bleeding, weight gain, fatigue and various pains) and switched to *IUD* but only remained on it for a few months and had it removed because of **excessive bleeding** (she thought if it wasn't removed it would kill her). When she went to clinic the provider didn't initially agree to take it out and was unable to explain to her why she had heavier bleeding, but in the end the provider did remove it. Since then she's been advising her village mates not to use these methods (although she acknowledges that while the methods didn't "suit [her] blood", others can tolerate them without problems). She is **motivated not to have more children** and has some regrets she's had so many and has not able to properly meet their needs. She is illiterate and attributes some of her difficulties to this fact. She reports that some **providers are slow**. She is interested in *periodic abstinence*.

Case 27

This illiterate 40 year-old mother of 7 is in a polygamous union. She was led to start contraception after a village-based sensitization activity. She reports not having been told about possible side-effects at the time of adoption. She only had injections twice and experienced various symptoms including **increased frequency of menstrual-like bleeding, weight gain, pain at the injection site and various other symptoms** not likely directly related to her method use (chills, fatigue). She says these symptoms have interfered with her ability to work. Like others, she describes her experience in terms of the method having "made her sick". When she reported these symptoms to her provider she was told they would diminish over time. However, she **feared *Noristerat*[®] would render her permanently handicapped** if she continued using. For these reasons (and because her **husband told her to**) she quit; she didn't go back to switch methods, assuming that the other methods would give the same problems. She mentioned **peers who quit because they'd lost their periods** - evidently dire interpretations were invoked. As her new method she will act cranky when her husband is in an amorous mood. Her husband not surprisingly is anxious for her to restart contraception. She would like another child but would like to wait about 3 years.

Case 28

After 6 children, this illiterate 33 year-old Akposso woman (in polygamous union) decided not to have any more, and **with her husband's approval** started on *Noristerat*[®]. She was told at that time by the provider that she might lose her periods while using. She's now been on it for almost 3 years and is motivated to continue to avoid pregnancy, however she is **disturbed by her loss of menses, despite reassurance by providers that it is a normal**

effect of the product. She reports that peers told her the injectable would make her sick. She is generally *satisfied with the service but reports some providers are slow.*

Case 29

This 25 year-old illiterate married mother of 1 was motivated to start because her husband wasn't content to continue post-partum abstinence. However, she "*didn't feel well*" after her first injection; she was *disturbed because she had bleeding 3 or 4 times over the two months after her injection and "[her] periods weren't clean"* (she reported that her provider hadn't told her about possible side-effects) and, most important, she was *afraid that Noristerat[®] would render her sterile or result in much prolonged time to conception* (it took a long time for her to conceive her first pregnancy). So, after only one injection, she *decided to quit.* Costs associated with getting the injections also contributed to this decision; she and her husband are quite poor. Her *husband*, in any event, *dominates decision making* and *his concerns about negative effects of Noristerat[®] appear to be the key reason for discontinuing.* She has quit using, resigned to a pregnancy earlier than she would have preferred.

Case 30

This 29 year old married mother of 4 started on *Noristerat[®]* after her 1st child (and was on it for 7 years). At that time, her provider told her that it could cause amenorrhea but that the loss of periods wouldn't lead to health problems and in any event if she had problems or concerns to return to clinic and the providers would deal with them. Beginning some months after the birth of her 4th child she started on *Norplant[®]* and has now been on it for a little less than a year. She switched because of fear of missing one of her bimonthly appointments. Her contraceptive use is *at her husband's prompting.* They have 4 children which he feels is all they can adequately support (so they don't want any more). She hasn't had any problems while on these methods although she says she doesn't know whether or not they may eventually make her sick. She reports having heard *rumors* that contraceptives can lead to later difficulties in child birth or cause *amenorrhea*, which in turn can lead *sterility* or *illness* sometimes serious enough to result in death. However she doesn't consider these stories credible and continues as a *satisfied user.* She has advised peers not to listen to such stories and that the providers will help pick out a method for them that "suits their blood".

Case 31

This illiterate 47 year-old mother of 7 reports a one-year period of abstinence after her last birth. She was on *Noristerat[®]* for 7 months beginning while she was with her first husband (*without his knowledge*). At one point she left him and became attached to another, who wanted her to have a child by him. Early in the interview she reports *quitting Noristerat[®]* not to satisfy his wish but *because of bothersome side-effects.* She *reports shortness of breath and widespread aches and pains* after her shots. She also reports *fatigue interfering with her work* and was *distressed by weight gain and having lost her periods.* When she does have bleeding, it is black, small in volume and protracted. She reports that it is *because* her menstrual blood is not coming out that she gets these other symptoms. *Despite her providers' efforts to explain the effects she was experiencing, she quit.* Later in the interview, she reports that her new *husband* initially supported her continued use and gave her money to pay the fees but at one point *insisted she stop* and she decided to comply (because she has lots of problems and he is helping her). She is now resigned to getting pregnant. She reports getting *good quick service* at the clinic. She believes that how one tolerates a method depends on one's body and one's blood. Everyone's blood is red

but there are differences. Diffuse pains that some women experience while on *injectable* come from their blood.

Case 32

This 48 year-old woman in polygamous union began using the *IUD* after her 3rd child (she now has 5, which is enough for her). She brought home the idea after a health talk at the clinic. Her husband went with her to see the MD and, once satisfied, agreed for her to have an *IUD*. With the *IUD* she was able to achieve desired birth spacing between 3rd and 4th and between 4th and 5th, after which her husband told her to switch to *Noristerat*[®], which she has now been on for about 4 years. She is a *satisfied user* and reports no significant problems with the method (although she has experienced dizziness) and feels it contributes to her good health. Peers have attributed her dizziness to method use, however she discounts their negative comments about the injectable. She reports that although she goes without bleeding for periods from 2-4 months, this is not at all disturbing to her. She has led a number of her cousins and other peers to start using and they have successfully continued to use. She says that others who started with her ended up quitting because “it made them sick” (loss of periods, heavy bleeding, pains, etc.).

Case 33

This 30 year-old mother of 3 was prompted to consider *Noristerat*[®] by her husband who had heard about it from a friend whose wife was on it. She explains that they settled on *Noristerat*[®] because her husband had heard that the *IUD can burst inside and cause damage*. Her *husband supports her continuing use*. She has been on it for 2 years and has had no problems. However, she often hears from peers *that contraceptives will destroy her uterus and leave her infertile*. She hears that *long-term use can cause infertility* but she isn't sure whether this depends on your body. Some fellow clients have quit in order to get pregnant and have had difficulty conceiving, despite taking all the traditional treatments. These *reports have evidently shaken her faith* to some extent. Her provider has tried to reassure her and her husband and she continues to use. She reports that she considers her provider a credible source of information. She feels that the *service is good and quick*. She intends to quit and start trying to get pregnant in about a year. Recently her mother consulted her, asking what she thought about her younger (single) sister starting on injectable. The mother asked if she thought there was a risk the younger daughter could end up sterile. Our interviewee didn't know how to respond.

Case 34

This illiterate 22 year-old mother of 2 was motivated to avoid pregnancy to advance her business and started on *Noristerat*[®] and used it for a year. As she was warned at her first visit, she *experienced changes in her menstrual bleeding, notably longer duration* (8 days vs. her usual 3 days) and after a time *this frightened her*. She reported going into the clinic frequently to treat her disordered menses. In the end her *husband insisted that she quit because of the expense* of these treatments. Almost a year later (after the study recruiter came visiting) she learned from her husband that he had discussed *Noristerat*[®] use with his *other wife*, a woman whose intelligence he respected. She refused to use *Noristerat*[®], saying that it was *harmful to health and fertility*. He evidently took that advice to heart, particularly the suggestion that its use could leave his wives sterile. Furthermore, he had decided he wanted another baby. Her preference would have been to remain on contraception for another year but she felt she had to submit to her husband's demand (all the more so because he had taunted her as a sterile woman). When deciding to try to conceive, she decided to go to the clinic for a *vaginal lavage* in order *to restore her fertility*. She reports not telling others about her *contraception* use, because it's *seen*

negatively by many in this milieu (equivalent to killing babies) and can provide ammunition for attack. Her sister was harassed by co-wives for using contraception, supposedly so that she could get rich. Her sister ended up quitting but hasn't been able to get pregnant since quitting 3 years ago. This contributed to the interviewee's *fears*. After the interview, she reported that both she and her sister have experienced a number of episodes of *pelvic pain and vaginal discharge*. [problems conceiving - PID-related?]

Case 35 - pregnant

This illiterate 30 year-old mother of 4, in polygamous union, reports a one-year period of abstinence after her last birth. She had heard about the benefits of contraception and was further instructed when in hospital, after delivering her last child. She returned a month later to start *Noristerat*[®] and hoped to wait another 5 years before her next child. However she quit after 18 months of use, *disturbed by symptoms* which she attributed to the method. She was *without menses* for much of that time (this she mentioned when listing its undesirable effects) and when she did have bleeding it was not like her usual periods (black with clots). Peers who were on injectable over the same period suggested that she experienced fairly complete amenorrhea (rather than bleeding every few months as they had) because she started on *Noristerat*[®] post-partum, before resuming normal periods. Other "side-effects" she reported included *feeling overheated*, and being *pale, weak and having no appetite*. She felt her *lower abdomen had become very hard* and reported that steam would rise off it when she washed. Although her *husband had supported her decision to start*, he *now insisted that she quit* - to see if she could get rid of these unwanted effects. She *quit without having sought advice or assistance from providers concerning her side-effects*. After having been off the method for 18 months, since at least some of these symptoms persisted, she returned to her providers who told her that at this point what she was experiencing couldn't be due to the method and prescribed her medication for her symptoms. Over this time, although she had wanted to delay the next pregnancy, she and her husband took no special precautions. She has now been without periods for 3 months and suspects she's pregnant. She reports she would be afraid to restart, for fear of developing the same symptoms and perhaps ending up dead.

She also tells the story of a relative who had an *IUD* and developed what sounded like a peritonitis requiring surgery, paid for by selling some of the family's land. This experience evidently *damaged the reputation of the IUD* in the area.

Case 36

This woman farmer and mother of 5 lives with her children and with a co-wife and her children. A third co-wife lives with their husband in another nearby village. He is motivated to limit the number of children (altogether with his 3 wives he now has 13 children) and doesn't want her to have any more. She accepts this but would prefer to have another. She *started on Noristerat*[®] *at her husband's prompting* (over the objections of his family) and continued for 4 years. Convinced they should stop having children, and having investigated and heard acceptable reports from a first small wave of contraceptive users from their village, *he* decided to have *all* his wives on contraception. Indeed she and her co-wives had, themselves, received positive reports from peers who had begun using. On beginning *Noristerat*[®], she experienced *menstrual changes*. Early on she had *6 months with no menses*, then a period of unpredictable irregular bleeding which cleared up and then later a prolonged (30 day) period of bleeding, and associated abdominal pain and sensation of heaviness; this happened again a couple more times. "It made me afraid." When one of her *sisters* found out about this she *insisted that she stop Noristerat*[®] *because it could do her harm*. She then told her *husband* she intended to stop. He *decided* around this time *to have her* and the other 2 wives *switch to Norplant*[®], but they refused, *fearing*

health effects. She *went to the clinic because of her menstrual side-effects* and was prescribed LoFemenal, which she took to no effect, so she decided not to return for more injections.

[It is interesting that for much of her discussion of experience with contraception, she uses the 1st person *plural*, referring to her and her 2 co-wives. Later in the interview she reported on one of them (living with her) who started on *Noristerat*[®] but quit after similar symptoms. Another was on *IUD* and it "migrated into the uterine muscle".]

On *satisfaction with services*, the interviewee mentioned once coming all the way into town for her follow-up appointment and going away without the injection because of a **stock-out**. She reports **being well-treated and promptly served**. She wouldn't advise anyone against contraception and invokes the explanation heard from many users and providers - "it depends on your body; each person's system reacts differently to the method". She comments that it is bad for a woman to use without her husband's authorization.

Case 37 (was refused service)

This illiterate but eloquent 45 year-old married farmer reports economic hardship to the point of hunger. It is this hardship (and difficulties she has with her pregnancies) that led her and her husband to adopt contraception (and she has continued to use *Noristerat*[®] with periodic gaps, most recently using for a period of 2½ years). She doesn't want more children. Their agreement came about this way: she gave her husband an ultimatum - abstinence until she started on a contraceptive method. Because of their poverty, her parents support her decision to use contraception. She and her husband have 7 children and he is unwell. She reports that some other women who would like to use are opposed by their husbands and inclined to use without their knowledge. She equates such behavior with infidelity. She has tolerated *Noristerat*[®] pretty well although has had **menstrual changes**. Sometimes she has very light spotting; at other times she has bleeding lasting 10 days or more and on one occasion it was as heavy as post-partum bleeding. She is quite **motivated to avoid pregnancy so takes these side-effects in stride**. She reports that there are times when she's had very heavy bleeding and wanted to go to the clinic for treatment but the bleeding itself prevents her from traveling so far (for fear of bleeding through the cloths she uses as a pad). She and others sometimes miss their follow-up appointments, usually because of **lack of money**. In some cases this results in women getting pregnant. She says that **when they come in late and report having had no sexual relations since menstruating they are not believed** and are obliged to go through the whole intake procedure again (along with its additional costs). She reports a recent experience when she was 5 months past due for her shot because she had gone back to her home village to take care of her sick mother. On return, before having had intercourse with her husband, she went to the clinic for her shot. But they expressed the suspicion that she was hiding a pregnancy, and insisted she restart the whole intake procedure; they examined her and insisted she pay the fee for a first visit. She **didn't have the money and was obliged to leave without having received the shot**. Her *peers* mocked her - pointing out that whenever she didn't have enough money she would just have to stay home and not get her shot. She also reports that users in general are mocked by others (especially the men) for wasting time and money on such a service rather than using the money to support their families.

Case 38

This 35 year-old mother of 5, in polygamous union, is illiterate but has lived in various places around Togo, has literate friends and seemed a little more cosmopolitan than some of the other Yoto interviewees. She is a continuing *IUD* user and has been on it for 2 years.

She began the interview with a theme expressed by others - 'these days, times are hard: there's no more money in Togo - we don't have the means of supporting lots of children (as was possible in the past). Now we have to limit the number of children we have so we can adequately support them.' Later she mentioned the rationale she'd heard from friends - that if one doesn't adequately provide for one's children they could grow up to become thieves. These arguments weighed heavily on her and she **brought the issue of FP up with her husband**. They also were encouraged by a health-worker friend to consider contraception. After 5 children, she and her **husband agreed** that because of difficult times, they should hold off on having more children and use contraception in the mean time. So she went on *Noristerat*[®] and was on it for 8 months. However, she was bothered by **menstrual irregularity** (especially protracted bleeding - 15-20 days) **and weight-loss** which she **attributed to the injection**. She **was concerned that if this continued she could get seriously ill**. So she and her husband went back to the clinic where they were **offered the IUD** without discussion of possible side-effects or complications or other alternatives (her preference would have been *Norplant*[®] but it was not available). She had it inserted and has tolerated it relatively well although she has had **occasional low abdominal pain and pain on intercourse** which she assumes is related to the *IUD*. On the *IUD* she has continued to **lose weight**, which puzzles her - she is now unsure whether the weight-loss was due to the injectable. Because of occasional pelvic pain, **she asked her provider to switch her to *Norplant*[®]** (which her 3 co-wives are on), but he told her that it was **not available yet** at his clinic (he did prescribe acetaminophen). She also reports **fatigue and a heavy feeling which she feels may be due to the IUD** and which slow her work. She reports that one of her **aunts has tried to pressure her to have lots of children** but that she is **content to submit to her husband's wish not to have many children**, (although after 5 boys she would like to have a daughter). She's encouraged in this position by several sisters-in-law. With regard to quality of care she mentioned that the **provider** to whom she has been going for some time (the clinician friend) has developed a **drinking problem** and that she felt he **didn't adequately address the problems she had with menstrual changes** (he never prescribed any medication for her menstrual problems on injectable).

Case 39

This 35 year-old mother of 4, in polygamous union, is a successful and satisfied contraceptive user with a contraceptive career with 3 different methods (and doesn't want any more children). She gives as rationale for contraceptive use that times are hard now and one cannot afford medical expenses related to pregnancy, birth and possible complications. That, for her, was an incentive to start contraception. She **started *Noristerat*[®] without her husband's knowledge** but **because of periods of protracted bleeding** (15-20 days) not adequately controlled by medication from her provider, after 3 years of use she **switched to the IUD**, which she tolerated well (indeed she reported that it made her more beautiful). Because she wasn't getting pregnant, her husband got suspicious and challenged her but she denied doing anything to avoid pregnancy. However, she reports that he was actually pleased to stem the flow of new babies and encouraged his other wives to watch her closely and do whatever she was doing to avoid having babies. So they confronted her, demanding to know how she was avoiding pregnancy and once she told them, they themselves started on *Noristerat*[®]. However they were ill-at-ease on *Noristerat*[®]; some switched to *IUD*, others to *Norplant*[®]. She herself, after 3 uneventful years of *IUD* use, started to be concerned about (unspecified) possible effects and decided to switch to *Norplant*[®] which she has now been on for 6 uneventful months. In the end all 4 co-wives were all happily on *Norplant*[®]. According to the interviewee this resulted in peace in the home as they all could comfortably make themselves available to their

husband without fear of unwanted pregnancy. She reports advising neighbors to use contraception *so as not to be encumbered by more children than they can afford to support*. Several she succeeded in interesting in contraception but they didn't have the money to pay clinic fees. As a reason for using contraception, she invokes women's well-being, not just the child's current and future well-being. Women suffer and would do well to be at least somewhat autonomous. Like many other interviewees, she gives as a rationale for providing well for your children that in due course, when one grows old, they will provide for you. Also, like others, she uses the metaphor of adequately spacing the plants in the field so that each grows well.

Case 40

This continuing user (demographic data missing) heard about contraception from the hospital, *raised the issue with her husband*, and *with his agreement started on Noristerat[®]*. She is motivated by the conviction of the importance of birth spacing for the health of her children, her own health, and her opportunities to pursue economic activities. She reports that she had no problems with *Noristerat[®]* for the first 2 years but then during the third and fourth years she had *prolonged stretches of time* (3-4 months) *without menstruating* (and with very light bleeding when it did come), and *diverse pains and weight loss which she attributed to the method*. She *told her providers about the menstrual changes (but not about the pains) and they tried to reassure her* that this was a normal effect of the product. She values such information. But, after *another 4 months without periods (still worried)* she raised the issue again and mentioned that she was having *pelvic pain*, in response to which they examined her and reported that she had a cervical lesion and then prescribed medication. She is uncertain whether it was caused by her *injectable* use - she asked but didn't get a clear answer from her provider. Likewise, although her providers have told her that her weight loss is unrelated to *Noristerat[®]*, she continues to harbor doubts. She reports having just completed her course of medication for the cervical lesion and having some improvement in her symptoms. She also reports that on experiencing such symptoms which she attributes to the method, she is *mocked by some of her peers* - "I told you so, I told you that using those methods would make you sick". She says that while at first she was concerned that these symptoms were due to her method, now she believes they are not (otherwise she would have quit by now). Persisting suspicions have shaken her confidence in *Noristerat[®]* to some extent although she doesn't want to quit because she's determined not to get pregnant. She interprets weight *gain* on *Noristerat[®]* as an indication that it is having beneficial effects on one's health and vigor: *to be losing weight while on the method* suggests that one's body doesn't tolerate the product - and continuing to use *could harm you*. Her *mother-in-law* has harassed her over her contraceptive use, but she says that this doesn't really affect her because she is convinced of the importance of spacing births. The times are hard - she says, and she has succeeded in convincing a number of her neighbors to use contraception.

7.3. Clinic Observations/ Interviews

7.3.1. Urban 1

Note, this was a busy clinic with over 30 clients seen by a single provider over a 4 hour period of time.

Client I

This 26 year old mother of 3 missed an appointment for her *Noristerat* dose and has come hoping she'll still be able to get her shot. She's pleased with the service at U1, especially the short waiting time. She previously was on the Pill but switched because she'd heard rumors that the Pill was a bad thing. She did get her shot and

the whole visit lasted a little less than an hour and a half.

Client X

had been instructed by her husband some time ago to come in to start on the injectable, but for whatever reason she didn't do so. Both agree now wouldn't be a good time to have another child. On a visit home he found she hadn't started and insisted she come in. She was in the day before but came too late and was instructed to come in the following day. Her whole visit lasted just under 1 1/2 hours. She left not entirely satisfied, since she was told she couldn't start the injectable until she was menstruating. From what the client said, it seems that she hadn't had unprotected intercourse with her husband since her last period, however the provider wouldn't take her word on this and so refused to start her on the injectable. She says she will come back but indicates that for some other women, such a refusal could result in the woman not coming back.

Client Z

is back for her 10th revisit on the injectable, and since it has been 5 visits since her last full check-up, she's now due for her vaginal/breast exam. As with the previous 2, she spent just under 1 1/2 hours at the clinic. She is happy with the service but finds the clinic at a greater distance from home than she would like.

Client O

This 39 year-old woman has 7 children and doesn't want any more (the cost of living is high and she doesn't have enough to support the children she has already). She briefly used the Pill after her last delivery and then she and her husband switched to the condom. Now, she's come to the clinic for her child's vaccination, but she's determined to leave having gotten a shot herself. She has not told her husband and indicates that it wouldn't be a big issue for him anyway since he has another wife who can make more babies for him (in her meeting with the provider she indicated that her husband had told her to come get the injection). On the other hand, it's important to her that he doesn't find out

and this is one her reasons for not wanting to have the IUD (she's afraid that with intercourse he would discover the IUD, by feeling it with his penis on penetration). She's also afraid of using the IUD because she has a neighbor who'd used it and ended up having to go for surgery. Although the injectable is her preferred choice, she is still somewhat put off because she's heard it can make you fat and she doesn't want to put on weight. Altogether she spent a little under 2 hours at the clinic. It's not altogether clear why she quit using the pill; when she was asked by the provider she refused to answer. Since quitting, she remained abstinent much of the time - this was feasible because her husband was able to sleep with the second wife. When she did have intercourse with him, he used a condom at least some of the time. At this point she doesn't want to go back to the Pill, not because it caused her any side-effects but because she's not confident she won't forget sometimes and therefore risk pregnancy (& because her husband could find the pills).

In the transcript we see an example of the standardized presentation of methods. In this case, the presentation came after the provider had received some background information on the client's circumstances and prior family planning use, although the actual formal assessment or history-taking happens at the end. The provider is too categorical about the degree of protection provided, suggesting 100% efficacy. She does give a fair bit of information on possible side-effects, telling her that "if it agrees with her body, she could put on weight" (without realizing that for the client this is *not* a positive feature), that she could get bleeding twice in a month, once in 3 months, light bleeding spread over a couple of weeks, or no bleeding at all - and all of this is just the effect of the medication. She also told her she could experience headaches, chest pain or leg pain and that if any of those were to develop she should return to the clinic. It's very important, she says, for her client to know these symptoms could develop so that if they do, she won't be anxious. Concerning what to expect on quitting the

injectable, the provider advised her client that it is necessary to menstruate, to clean and prepare the uterus, before it would be possible to get pregnant.

She also seemed to nag the client a bit over having not come back when she quit the pill, but it was good-natured and the client reported that the treatment she received resulted in dissipation of her initial fears of rough treatment. She appreciated the service, feeling that she was seen promptly and that the provider made an effort to understand her. In this case, although the client was past her period, the providers trusted her word that she hadn't had unprotected coitus, and consented to start her injections that day. On leaving, the client reported that she was pleased with the outcome, having gotten the shot she'd come for. She's reasonably confident that it will work out for her despite what people had told her about how it could make her sick or fat (neither of these concerns were really elicited or addressed by the provider) and she says that if it doesn't work out she'll just switch methods.

Client Y

This prospective new user wasn't able to convince her husband in the past, but a neighbor recently had an unwanted pregnancy; furthermore, he's been frustrated with periodic abstinence, so he abruptly changed his mind and now wants his wife on injectable. The encounter is transcribed; the provider got a little bit of information from the client right at the start because the client volunteered it, not because the provider was trying to elicit it. She very quickly launched into her standardized presentation of methods. The information tended to be presented in a rather categorical way (i.e. suggesting 100% efficacy with correct use) and with subtle biases. Her tone was pretty consistently jolly. On discussing the *Pill* she told the client that it had an effect of "purifying" her periods and purifying her blood. [Is she referring here to the FeSO₄ included for days 22-28?] She also implied that one is likely to experience nausea, vomiting and headaches while on the Pill and that if one does, one should be seen in clinic. She gave inaccurate

information on return to fecundity on quitting the Pill - the month you quit you can get pregnant any time, whether when menstruating or at the time of ovulation.

On the *injectable*, she told her client that if it "suited her body, she could put on weight". She went on to explain that "some women on the injectable have slight changes in their menstruation - they could have bleeding twice in a month or it could come in very small amounts but spread over a number of days or it could be once every couple of months or not at all - in any case it's just an effect of the product." On non-menstrual effects, she told her client that when they give the injections, "some women have headaches, double-vision, or dizziness and in any case these are just effect of the medication and the body will end up adapting to it". "Now that you've been informed and if you have these effects you won't be anxious because you'll know they're just an effect of the medication".

Later, she gave inaccurate information on menses and return to fecundity after discontinuation: she evoked the common idea that one remains incapable of conceiving until the first menstruation, which serves to "clean out the uterus". During her standardized presentation of methods, information given was in some cases sketchier than what an adopter would need and in other cases too detailed if the client wasn't going to be taking that method.

The general pattern is 1) a brief social introduction (which may elicit a little information on the client), 2) standardized - not individualized monologue presentation of methods, tending to be a bit too information-heavy, 3) ask client her preference, 4) additional information on chosen method (if necessary) - in this case the only additional information was that given in response to the client's questions, 5) elicit detailed information to fill in the clinic file card.

The provider also insisted on a pregnancy test although the client reported having her last menstrual period within the past week - so the pregnancy test would be useless. The provider didn't go through a medical history to determine if there were medical

contra-indications. Evidently some aspect of her description of the injectable led the client to believe that, although it had been her intended method - it would not work for her and she would have to make another choice. Perhaps, when the provider mentioned hypertension and varicose veins as a contraindication, the client believed that she had some such exclusion. Perhaps instead, it was the description of the process of purification of the uterus before regaining fertility that put her off. This is interesting indeed as it seems to indicate possibly unintended effects of provider counseling on client method choice. Given that the encounter is so *one-way*, one should not be surprised to see less effective coming-together of client needs, circumstances, preferences and provider knowledge/ expertise in arriving at a choice of method and ensuring that the client gets off to a good start, with all the needed information, etc. If the client misunderstood, the provider wasn't in a position to pick up on this and correct any misconceptions. In any event, the outcome of the visit was that since woman was not menstruating, she needed a pregnancy test. She was to return the next day with more money to do the test. At that point, if allowed, her intention was to have Norplant[®] inserted.

7.3.2. Urban 2

Client A

This client has 4 children and doesn't want any more (she has to work hard to support them and send them to school). She reports a long interval between her 1st and 2nd child due to fertility problems which were solved by taking herbal treatments. She's been on the injectable for 1 year and 9 months and has come to the clinic for a regular injection. She spent 2 hours there, a shorter than average visit according to her. We observed respectful warm service however she noted that at times the providers are hostile. She also noted problems with adequate staffing for the volume of clients, this leading to longer waiting time and poorer provider behavior. She reports that after initially having regular periods they stopped and she told her providers. One of them

examined her and told her that her uterus was bent over and prescribed medication to correct the problem. Since then things have been going well and she reports no problems of aches or pains but she still isn't having her periods.

Client I

She used injectable for 3 years without problem except for weight gain. She quit however, because she lost her periods, and remained off the method for a year before starting again. She then continued for 2 more years and then quit to have more children (she had 2, but 1 of them died). She now wants to start on Norplant[®]. She hopes that she will be able to afford it and that it will be inserted today. She is observed, while waiting, to seem restless and somewhat fearful. She ended up at the clinic for 3 hours and didn't get what she wanted; it was too expensive. Furthermore, because the cashier was closed for a two hour lunch break by the time she got to that stage, she wasn't able to go make the payment to get the injectable (which she could afford). So she left with no contraception. Nevertheless she remains motivated to start family planning as she doesn't want another child right now.

Client J

has used Norplant[®] for 30 months and comes in now with an appointment to have it removed (she reports that she'll adopt another method later). She reports over the last year and a half having shortness of breath and various aches and pains which she attributes to the method. She is at ease with the provider but determined to have the implant out. Her provider tried unsuccessfully to dissuade her. The client was shocked by the cost of removal (3000CFA) and the observer had the impression that she was very dissatisfied with her Norplant[®] experience and would likely recount her negative experience to peers.

Client K

is an injectable user who has come for her regular shot. Her provider began by asking if she'd had any problems (she had none),

then asked what side-effects she'd been told about in earlier visits. She said she hadn't been told about possible side-effects. The provider then asked if she hadn't been told about head-aches or spotting. "No." "You've lost your periods?" "Yes" "Any pains?" "No." "And have you put on weight?" "Yes, I wasn't like this before." The provider then has her repeat back possible side-effects. The observer found the provider's manner warm and respectful.

Client N

This woman has had Norplant® in place for 5 months; she had no bleeding for 3 months and now is having vaginal bleeding associated with a foul odor and pelvic pain. [It sounds like they may be due to infection rather than a side-effect of Norplant®.] Because of these effects she says she wants the Norplant® out and to start on Noristerat® ("people say it's more effective"). Her provider discounts this statement, "people lie, they're both the same". She then asks her client to recite what she was told about possible side-effects when she had the implant placed. She responded by listing the various possible menstrual changes and then mentioned pelvic pain. The provider then examined her, noted a foul odor and prescribed medication (presumably for infection) but didn't make clear to the client whether she was treating side-effects or something else. She asked her to come for a follow-up visit in a month. The observer noted that the provider had a warm reassuring manner and gave her client the opportunity to express her concerns.

Client X

This Ghanaian mother of 3 has been on Noristerat® in the past (for 27 months) and reports that when she was last using it, her only side-effect was light irregular bleeding but that, since she'd been warned in advance, it didn't worry her when it happened. In fact, before going on the injectable she had painful cramping with her periods and she was glad to have this suppressed while on the injectable. She quit to have another child; he is now 2. Although normal periods haven't come

back yet, she is worried because a friend of hers fell pregnant even before the return of her menses. It is important to her to avoid a pregnancy until her child is bigger. Furthermore, her husband is a long-distance driver. When he comes home sometimes he uses a condom. He's now back home, using condoms, and supportive of her desire to start again on the injectable. She came to clinic for the first time yesterday at 10:30 but was told it was too late and so she returned today at 7:30 and was observed in discussion with other women in the waiting room, talking about their contraceptive experiences. She was warmly received by the provider, who began by asking her the reason for her visit. The client briefly described her personal situation and reasons for wanting to be on the method. Although she made it clear she'd been on the injectable before, wanted to start on it again, and felt she already knew enough about the other methods, the provider immediately moved into her standardized presentation of methods. There was no assessment before beginning the counseling. In this presentation she focused on effectiveness and mechanism of action of the different products. She, inaccurately, reported that a normal possible side-effect of the IUD could be amenorrhea. When she got to the discussion of injectables she told her client to take particular note, since this was the method she wanted. She told her, inaccurately, that after discontinuing both Noristerat® and Norplant®, return to fertility could be delayed a year or more. At this point the client interjected that after quitting she had waited 6 months before getting pregnant. The provider discussed different methods but steered her away from the pill (saying that it was not as effective) and the condom (saying that while it's very effective, especially for preventing infection, it doesn't concerns us). She gave a vague description of periodic abstinence methods but again emphasized their unreliability and ended by describing the mechanism of vasectomy and tubal ligation. Once she had gone through her presentation, she asked which method the woman wanted and then provided some additional information on the injectable, this time

describing some of the possible side-effects (in this order) - spotting, headache, pelvic pain, chest pain, amenorrhea (“possible for some”), discomfort, and change in menstrual pattern. If any of these symptoms develop the client was told she should return to the clinic. After this information session, she examined the client and then questioned her to fill in medical history details on her clinic record. She then asked her to repeat what she had presented on possible side-effects of the injectable and when her client didn’t answer, said - ‘so you’ll go home and start to have spotting and you won’t remember what I’d told you about that’ (failing to recall that this is a woman who’s had over two years experience on the injectable). With this prodding, the client recited a list of possible menstrual changes and mentioned head-ache as side-effect of *other* methods. The provider corrected her, saying that for the side-effect discussion she was only talking about the injectable, not about other methods. The injection was given and the client sent home with the advice not to have sex with her husband for the next week and to return to clinic if she developed bad headache. In this case the provider didn’t insist on the woman menstruating to start on the method. In the debriefing, the client expressed slight exasperation that the provider had insisted on discussing all the other methods when she’d made it clear what she wanted at the beginning. She left the clinic just over 2 hours after arriving. She commented on long waiting time and suggested they needed more staff, given their heavy client load.

Client Z

This 37 year-old mother of 4 sons (who eventually would like a little girl) expects to continue on Noristerat[®] into the foreseeable future. She will be out of town the day of her next RDV and wants to get her shot early. She’s used injectable for just under 3 years, having started without her husband’s knowledge although now he’s aware. “It went very well at the beginning, with normal periods” (and weight gain, which later stabilized), but then there was a period of heavy

prolonged bleeding; she thought it was a serious illness and went back to the clinic. Her provider explained that it was not serious, it was just an effect of the medication. Her symptoms then resolved after a short period on the pill. Since then she has not menstruated. Beginning 3 months after that episode she reports experiencing pelvic pain but didn’t initially tell her provider. She thought it was simply the consequence of having lost her periods. The provider began today’s encounter by asking if she had pains anywhere, to which she replied, No. She then asked what had been her experience with side-effects since she’d been on the method. The client recounted her experience with disturbed menses and then amenorrhea. Again the provider asked, “since you’ve lost your periods have you had anything else?”

“No.”

[Again] “Any pains anywhere?”

“Just in the kidneys [i.e. pelvis/low abdomen]”

“It hurts, but not too bad?”

“Yes”

“It doesn’t bother you?”

“No”

She then asked what the client remembered about being told about side-effects that could develop. She said she remembered she was supposed to examine her breasts and armpits for lumps and with specific prompting she confirmed that she was also told that her periods could change and that she could have pelvic pain. The provider moved on to talk about possible loss of libido and then weight gain. She then did a physical exam and gave her her shot. On leaving, she charged her client with countering rumors that the injectable kills or causes terrible headaches. In debriefing the client reported that she was satisfied and she felt well treated, as she usually is (although she reports they get angry when you’re late). She spent just under 3 hours at the clinic (finding it a little long) and feels the clinic could be better organized or staffed to reduce waiting time.

7.3.3. Urban 3

Note, this was a busy clinic with over 30 clients seen by a single provider over a 4 hour period of time.

Clients A&B

A pair of young single women have come to the clinic for information about family planning (they were first sensitized to the issue because of a visit by our team to conduct an interview in their household). The provider began by asking the reason for their visit and then making a general plug for family planning use for its birth spacing benefits despite the fact that her clients had just told her that they were apprentices and interested in family planning in order to DELAY starting to have children. They told her at the beginning that they were interested in the injectable. She jumped right in with her standardized presentation of methods, method by method, ending by telling them they could come back when they were menstruating or could have a pregnancy test. She didn't ask them if they were sexually active. She dumped lots of information on them, information more oriented to married women (in fact she consistently addressed them as if they were married women, e.g. during discussion of IUD - "if your husband is having extra-marital relations he can bring home infections"). Finally she spent less time talking about condoms and STD/HIV prevention than about any other method, including sterilization, saying only "there are other methods like the condom, which is good for preventing AIDS and sexually transmitted diseases." For the injectable, she explained that it can cause amenorrhea but that this is not serious, it's just an effect of the product. Other women will continue with their periods or have irregular light spotting; that's normal too, it all depends on your body. But if it happens that the women gets heavy bleeding that persists a week or more, she should come back to the clinic rather than spreading bad rumors on the street corners. She insisted that IUD users must "keep their bodies impeccably clean" if they are to avoid infection and indicated that with the Pill it's very likely you'll get

side-effects (unspecified). A recurrent theme in her talk was on confronting malevolent anti-family planning rumors. At the end of the talk she asked them which method they preferred. Injectable, they answered. But at that point she brought the session to a close, indicating they would need to come back another time (either while menstruating or have a pregnancy test). At that time she would examine them and decide on that basis which methods they were eligible for, giving as an example that if they weighed too much they couldn't get Norplant®. She did no assessment - did not determine if either had any prior experience with family planning, current sexual activity, what their needs were, were menstruating at the time of the visit etc. And she did not offer condoms or spermicide (assuming perhaps that her client were not sexually active, although she had mentioned pregnancy tests for their next visit). The observer noted that the whole encounter had a jolly air and the young women left in a good mood.

Client E

After an informational visit to another clinic and a discussion with her husband they decided that she would go on Norplant®. She went back to that clinic and, as she explained to the provider, requested Norplant® but was turned down because she weighed too LITTLE (although she told our interviewer in the waiting room that she was refused Norplant® simply because there wasn't a provider available trained to do the procedure). Instead she was offered the IUD, which she accepted. However, she reported to our interviewer that she experienced severe pelvic pain beginning almost immediately after insertion. Her husband was angry that they had given her the IUD rather than Norplant® and insisted she return to the clinic to have it removed. She returned 3 days after the insertion but the providers did not examine her, did no tests, provided no treatment and refused to remove the IUD until she'd had it in place for at least a month. Her husband was angry and threatened her - so she contacted the provider at U3 and came to the clinic for removal. The observer in the

consultation room noted that the client seemed very cowed and submissive, as if expecting abusive treatment. During the consultation, the client did not mention pelvic pain at all. The provider was reassuring and supportive and removed her IUD. She also gave additional information on Norplant[®] (including on the insertion process), particularly addressing rumors of its ill-effects. She also explained the use of spermicide. She gave her spermicide and told her she would need to return at the time of her next period if she wanted to start a new method (despite having just taken out the IUD). The client left clearly quite relieved, leaving the provider with the impression that she would return at the time of her next menstrual period. During the debriefing interview, however, she indicated that she had told the provider she wanted to wait a little while for her system to get back to normal before starting another method. She was discouraged by the attitude of providers at the other clinic and by her bad experience with IUD. "They should listen to us, they are supposed to be there for us. But some of them don't know why they chose their profession; they're nasty, not welcoming and gentle at all. But here at this clinic she was very nice. I'm satisfied today." Nevertheless she does want to start because she definitely doesn't want another child right now (raising them in these times of pinched resources is so difficult).

Client F

This 25 year-old woman used to be on the IUD (until about 4 months before this visit) and evidently had it removed because of a pelvic infection. She now returns 4 months later complaining again of severe pelvic pain. After examining her, the provider tells her she has a tender mass in the uterus. She then tells her that some [vaginal and/or cervical?] swabs will need to be done and that she will need to be seen by another clinician colleague of hers and then takes her across the hall to the MD. On return, the provider gives the client instructions on an anal suppository she is supposed to take to treat the pain and on going to another facility, on

another day, so that swabs can be done. The observer noted a warm sympathetic manner on the part of the provider.

Client Y

This prospective new user explained at the beginning that she wanted the injectable. The provider launched immediately into a standardized presentation of methods, explaining the mechanism of action. On the IUD, she emphasized the necessity of cleanliness, because the IUD traps microbes. She explained it could give rise to pelvic pain and spotting. While on the IUD, it's necessary to come to clinic from time to time to have it cleaned. She touched on the Pill very briefly, only noting that it had to be taken daily, without exception. Norplant[®], Noristerat[®], and Depo-Provera[®] were discussed together. She explained that with these methods "at a certain point, you won't have periods anymore because eggs aren't being produced, or on the other hand periods could continue normally - it all depends on your body. Or at the time of your periods, you could have just a little bit of bleeding for 2 or 3 days but it could start again a couple weeks later. If you get a very heavy flow and it continues for a week or more, you come back to see us." She then gave use instructions on spermicide and condoms and ended mentioning tubal ligation. Then, "the rule is, you need to be menstruating or have a pregnancy test. Which method would you like?" The client reiterated her desire to start on injectables. The provider however told her, 'you have to weigh less than 70 kg to be on the injectable and our scale doesn't work so you'll have to come back another day and we can check you.' Without any questions at all about the woman's reproductive intentions, her current status or sexual activity, the provider indicated that they would need to do a pregnancy test.

Client Z

The client came to clinic (with her husband's approval) to get an IUD inserted (4 months post-partum). For some reason, the provider started by asking this client if her husband was in agreement that she start family planning. Before

beginning her standardized presentation of methods, she also asked a few questions including whether or not the woman had resumed intercourse postpartum, to which the woman replied that she hadn't; this was immediately followed by the provider indicating that a pregnancy test would be necessary (without questions about whether or not she was menstruating). However the woman only brought enough money for the IUD that she and her husband wanted, not the 3000 CFAs that the pregnancy test would cost. The provider advised her to buy some spermicide. But the client ended up going away empty-handed, not even getting the presentation of methods.

Client G

This woman, recently returned to live with her husband in Lomé and, 4 months postpartum, came to clinic wanting Norplant[®]. The provider presented the various methods after which the client indicated again that she wanted to start on Norplant[®]. However the provider refused on the grounds that she weighed too much, was amenorrheic and breast-feeding (she was visibly fat, although she wasn't weighed because the scale was broken). She refused the offer of spermicide and was clearly displeased with this outcome. The observer found that the provider displayed a forced warmth during her interaction with the client.

7.3.4. Rural 1

Client A

This client is a continuing injectable user. The provider reviews with her information about expected side-effects. She remembered that even if you haven't had a period in a long time that wouldn't create problems. (She reported having had bleeding earlier in the month.) The provider reiterated that "it all depends on your body." "Some women have their periods normally, others not at all, or light spotting, or a flow almost like a normal period. If that happens, women can come back and we can help them. Some get head-aches or weight gain. Other don't put on any weight. After quitting, you could wait 1,2,6 months, even 1 or 2 years

before getting pregnant. Have you had periods while you've been on the injectable?" The client reported, yes, everything's been fine. After further instruction about the importance of not missing appointments, the client was given her shot and sent on her way.

Client C

This woman was initially motivated to start family planning but her husband didn't support her; so she ended up with an unwanted pregnancy, after which he agreed that she start family planning. They now have 5 children and she doesn't want any more. She started on the injectable and has been on it for 4 years. This visit, she has arrived 8 days late for her injection evidently because of difficulties in getting transport from her village. The provider lets the client talk, successfully eliciting her concerns. During the consultation the client reports that she had gone some time without bleeding but her most recent menses (beginning 9 days ago and still continuing) has been heavy and associated with quite a bit of pelvic and low back pain. She makes a comment suggesting her confidence in the provider as a resource to help her deal with such problems. There seems to be a discrepancy in the accounts the woman gave of the timing of her uncomfortable menses between what she gave the provider and our interviewer (to whom she reported that it occurred 6 months previously). In the debriefing interview, the client commented that because of side-effects many people have only negative things to say about family planning.

Client I

This returning injectable user has 5 children and started on the injectable 1 ½ years ago at the prompting of an older sister (she didn't choose IUD because she'd heard that it can cause a lot of pain). When she first went in, she appeared worried about the provider's response to her being 2 days late for her appointment. The provider queried her on what she remembered as possible side-effects. She then asked if she'd been having her periods. The client responded, yes, but since she'd started on the injectable her

periods had been irregular, going as long as 3 months without bleeding. But in recent weeks, she had had a spell of 2 weeks of bleeding, which worried her. She would eventually like to have a 6th child but is concerned that the method may have brought on a premature menopause. The provider reassured her that the method can in no way bring on menopause and suggested that she not pay attention to rumors about contraception. The observer noted that the provider seemed polite and the client somewhat fearful and submissive, although she expressed her satisfaction on leaving.

Client J

This new client doesn't want more children. She has 6 now, the youngest of which is 3. She has come in for contraception for the first time, having relied on abstinence to this point. Her sisters have encouraged her to adopt family planning and she was also encouraged by providers in the well-baby clinic to start on injectable. She made it very clear during today's visit that she wanted Noristerat[®] and stated so several times during the presentation of methods (making it fairly clear that she wasn't interested in hearing about the other methods) but the provider insisted on pushing on with her brief descriptions of mechanisms of action and use for each of the methods. She seemed to call into question the effectiveness of the injectable, informing her client that it varies by person. She gave an imprecise enumeration of possible side-effects ("some have normal periods, some - none at all, some - light irregular bleeding; it's just an effect of the shot") and then reassured the client that whatever effects she has - not to worry, you're not sick, it's just the effect of the medication. "If you have heavy persistent bleeding, you come back to see us." The provider did inquire in some detail about her client's circumstances related to family planning and conducted a fairly thorough assessment to complete the medical file (after presenting the methods). Also, during this assessment phase she questioned the client on what she recalled about possible side-effects of the

injectable (client was able to report back key points). She also asked the client her reasons for choosing the injectable. She replied that it is because it is discrete; she doesn't want her husband to know (she's uncertain whether or not he would support this decision). The IUD she is afraid of because her neighbor, who was on IUD, had to have an operation to have it removed. She's also concerned that her husband could feel it while they have intercourse and that would give away her secret. Similarly, her husband could find her pills, going through her belongings. Also she could forget to take them. The provider gave her the first injection, without insisting on her menstruating or having a pregnancy test. She also advised her to use spermicide and have her husband use condoms over the coming week. The observer noted that the client was at ease and left quite satisfied.

Client K

This woman first had her IUD inserted 3 years earlier in Lomé (no prior use of contraception). She is now resident in a village 25 km from the clinic. She has had 7 children, 2 have died. On a previous visit to the Lomé clinic they found cervical "ulcerations" and prescribed treatment which didn't cure the problem. She says her periods are fairly heavy but tolerable. The provider examined her (the observer, who is also a nurse-midwife-medical assistant, felt the lesions were "vaginal polyps") & reported that there had been some improvement but at her next visit she would have her seen by the doctor or medical assistant & in the meantime prescribed a new medication. She reassured her that it wasn't necessary to remove the IUD.

7.3.5. Rural 2

Client X

This woman walked 6 km into town for her follow-up appointment to get her Noristerat only to find that she didn't have enough money. So she went back home and returned the following day. She's had 3 injections so far, has had some menstrual irregularity (with stretches up to 2 months with no bleeding) which hasn't

really been a problem for her, has had problems with heart-burn after her second injections, and (sometimes intense) headaches more recently. The headaches she's been treating with acetaminophen and chloroquine. On arrival, her provider noted she was a bit late for her shot. She asked how it had been going for her with the method. She asked specifically about her periods, to which the client reported that they were normal. The provider elicited the information about the headaches and how she'd been managing them. She commended her for appropriately using acetaminophen but then advised her that she should only use chloroquine if she really thinks she could have malaria - and if she takes it, she needs to take it properly. She then instructed her on the proper dose and schedule, and continued with questions about her knowledge of injectable side-effects. The client was able to report back that one can anticipate menstrual changes. When the provider asked whether irregular menses constitute an illness, the client replied, no it's just an effect of the product. Overall, the client was warmly received and seemed at ease with the provider. On exit interview the client expressed her satisfaction. She compared providers here favorably with those she's interacted with at her previous clinic (they frequently treated clients badly and would expect tips). That, plus rumors that the injectable could make you sick, combined to keep her from starting.

Client Y

This client is 28 years old, has 3 children, and doesn't want any more. She hasn't used modern contraception before. Her usual method has been a form of periodic abstinence, starting 5 days after her period ends and remaining abstinent for the following week. Since her last birth she has used pills from the market, 2 of which she swallows before having sex. Recently she and her husband decided to adopt a modern method and she came to the clinic to request IUD (her sister-in-law has been a satisfied IUD user for 8 years). She was given a briefing on the different methods, indicated her choice, but was told she couldn't have it placed that day and would need to return when she was menstruating.

So she has and is again subject to another standardized presentation of methods, this time beginning with a review of general reproductive physiology. The provider briefly described periodic abstinence, noting that the woman should document her periods and then review them with the midwife to determine which are her safe days. She then proceeded to briefly describe tubal ligation, vasectomy, lactational amenorrhea method, condoms, and spermicide (mentioning local irritation as a possible side-effect). Then, in some detail, she described the proper use of condoms and continued with a brief mention of the mechanism of action of the IUD, then the pill (mentioning that it could produce changes in the menstrual cycle, "periods could come, or not come"). She also explained that with the pill you will have a little breast pain and swelling, as well as head-ache (controllable by acetaminophen). 'Periods may or may not come, and could come in small volume but over a prolonged period of time. In any case, after the first month, as your body adapts, these symptoms will diminish.' On Norplant[®], 'some women will have changes in their menses, others not. If their periods stop, some women report heaviness in their kidneys, or the periods could come but in small volume continuing for a long time. If that happens, come back to the clinic; there is a product we can give you to take care of that.' Then, as the client's chosen method, the provider turned to the IUD. 'As you recall, if you have painful menses or your husband travels a lot, we can't give you this method... The advantage of this method is that it is a little thing and it isn't a product that mixes into your blood and affects your body - but it needs care, it doesn't like uncleanness.' She then went on to explain that "intimate hygiene" involving putting fingers in the vagina, especially at the time of menses, risks infection. She then examined the client, noted a lesion on the cervix (she did not report any discharge), and indicated that she couldn't insert an IUD; the client would have to choose another method. She also reported that "no doubt the infection had gone into her uterus and she would have to take medication"; she didn't

mention any need for treating the husband. The client declined making a definitive choice of another method, stating that she would need to discuss it with her husband. The provider then gave her spermicide & detailed instructions on its proper use (followed by a quiz to confirm she'd retained the information). She also gave

her Doxycycline, flagyl, and mycostatin [i.e. shot-gun for vaginitis plus coverage for chlamydia but not for GC]. Not having received an IUD, she left not entirely satisfied however she felt the provider gave good service and she appreciated all the detailed explanations.