**RACHA Studies**
**#11**

# A Study of Birth Spacing in Siem Reap Province

## Dropout and Late Clients

# A Study of Birth Spacing in Siem Reap Province

## Dropout and Late Clients

**Sponsored by:**

**The Ministry of Health**

**The Provincial Health Department, Siem Reap**

**The Reproductive and Child Health Alliance (RACHA)**

**Report Produced by RACHA**
**August 2000**

**RACHA is funded by the United States Agency for International Development (USAID). However, the comments and conclusions of this study do not necessarily reflect the opinions, policies, or beliefs of USAID**

# Table of Contents



**Tables**

# Executive Summary

The Reproductive and Child Health Alliance (RACHA), funded by USAID, in cooperation with the Provincial Health Department of Siem Reap province and the Siem Reap Operating District, conducted the Birth Spacing Dropout Study (BSDS). During the first quarter of 2000, 125 late birth spacing clients and 125 discontinuing (dropout) clients were interviewed about factors related to the use and dropout from oral (COC) and injectable contraceptives. Qualitative data was also collected through in-depth interviews with a sub-sample of these clients.

**Major Finding**

- Women who dropped out did so primarily because of side effects, time requirements - "too busy" - for obtaining services, or their decision to have another child.

- Many rural women who were using birth spacing were doing so for the first-time or were repeat "spacers," using the same method between pregnancies.

- Most women who were using pills or injectables had been doing so for less than one year.

- Most women experienced side effects from pills and injectables. The lack of readily accessible birth spacing services, particularly counseling, leads many women, especially younger women who have not yet had their desired number of children, to be intolerant of side effects.

- Many women who were dropout or late clients were "too busy." "Too busy" reflects the very limited access to birth spacing services that rural women confront due to inadequacies in health center operations and weak staff skills, especially counseling.

- In addition to physical side effects that contribute to women dropping out or being late, an equally important set of factors was the fit between method requirements and the client's daily routine and work schedule - her life style.

- Some women who were late for their next re-supply of pills or next injection had either already decided, or were in the process of deciding, to discontinue use of that method temporarily or permanently.

- When women discontinued pills or injectables, the large majority of them did not switch to an alternative method.

- The large majority of women who dropped out decided to do so on their own. Someone else rarely made the decision, e.g., husbands, mothers or health center staff.

- The majority of late clients planned to continue using birth spacing and a very large majority of dropout clients planned to use birth spacing again in the future.

- Approximately one third of women using pills or injectables did not expect these methods to have long-term adverse effects on their health. The majority of women who anticipated negative health effects had expectations that were based largely on misconceptions about hormonal contraceptives.

- Women using pills or injectables most valued the effectiveness of the contraceptive in preventing pregnancy and that it makes them feel better - physically and psychologically. Injectable users highly valued the ease of remembering correct method use, while pill users valued the fact they have a regular menstruation and the ease (convenience) of pill use.

- Approximately 40 percent of women using birth spacing expressed no dislikes of their method. What women did dislike were the side effects of hormonal contraceptives. Some pill users disliked the difficulty of remembering to take a pill daily, while some injectable users disliked the lack of regular menstruation.

- Only on third of women using birth spacing knew when their scheduled next visit was for pill re-supply or injection.

- Many women using pills or injectables were, in fact, not attempting to space their next pregnancy, but were trying to avoid pregnancy entirely. These women did not want another child; however, most were unaware of permanent or longer-term methods to prevent pregnancy.

- Many of those who had heard of tubal ligation were afraid of the procedure because of various misconceptions, or they thought that the cost of the procedure was prohibitive.

An important conclusion to be drawn from this study is that dropout from method use reflects supply constraints. The supply of birth spacing services of appropriate quality is not sufficient. As the responses of these women show, interest in delaying, spacing, and reducing the overall number of pregnancies clearly exists. However, the demand is unmet by current service provision. To increase prevalence and reduce dropouts, the supply of birth spacing services to meet the existing demand must be expanded. The solutions, therefore, must come from the providers of birth spacing services in both government employment and in private practice. In line with these conclusions, the following recommendations are made.

**Recommendations**

***Recommendation #1*:** The MoH and its partners should develop a continuing education system give much greater attention to upgrading the skills of health center staff

- particularly midwives - by strengthening counseling skills and technical knowledge about method options and management of side effects.

***Recommendation #2:*** A program of one-on-one facilitative supervision should be established at health centers and during outreach visits where resource persons observe birth spacing services and help providers improve their skills

***Recommendation #3:*** Health center staff need to provide birth spacing services to clients at times other than their standard morning operating hours, such as by assuring that at least one qualified service provider is at the health center for two or three hours each afternoon.

***Recommendation #4:*** Health centers need to conduct outreach visits to villages on a regular and predictable basis. These visits should include the full range of birth spacing services, e.g., promotion of birth spacing; counseling about method options; re-supply of pills, injections, and condoms; counseling for women experiencing problems; and promotion and counseling about longer-term and permanent methods.

***Recommendation #5*:** As part of skills upgrading and facilitative supervision, greater attention should be given to "life style" factors in counseling clients about method options, and management of side effects.

***Recommendation #6:*** Health center staff who conduct a private practice should be encouraged and assisted as part of skill upgrading activities to provide birth spacing services to their clients, including active promotion of birth spacing to increase prevalence and expand a potentially important part of their private practice.

## Acknowledgements and Acronyms

RACHA expresses its appreciation to the following individuals whose efforts made this study possible:

- **Health center midwives:**

  Pen Monyroth - Kandek health center
  Ky Kalyan - Samrong Yea health center
  Chhouk Kunnary - Pourk health center)
  Ly Sokun - Mondol I health center
  Kiev Vantha - Chriev health center

- **Interviewers from Ministry of Woman Affairs:**

  Neth Sarorn - Kandek health center
  Pat Sophea - Samrong Yea health center
  San Proun - Pourk health center
  Heng Khim - Mondol I health center
  Sy Vanny - Chriev health center


## Acronyms

| | | |
|---|---|---|
| BSDS | - | Birth Spacing Dropout Study |
| COC | - | Combined Oral Contraceptive |
| CPR | - | Contraceptive Prevalence Rate |
| IUD | - | Intrauterine Device |
| KAP | - | Knowledge, Attitudes and Practice (study) |
| MoH | - | Ministry of Health |
| MWA | - | Ministry of Women's Affairs |
| RACHA | - | The Reproductive and Child Health Alliance |
| USAID | - | United States Agency for International Development |

# A Study of Birth Spacing in Siem Reap Province: Dropout s and Clients who were late for Scheduled Services

## 1. Objective

The Reproductive and Child Health Alliance (RACHA) in cooperation with the Provincial Department of Health of Siem Reap and the Ministry of Women's Affairs, conducted a survey of 250 birth spacing clients of five health centers located in Siem Reap Operating District. The purpose of the survey was to obtain information about the factors associated with dropouts from a birth spacing method or being late to obtain scheduled services.

## 2. Background

The contraceptive prevalence rate for modern methods among currently married women is estimated to be around 16 percent. With such a low rate coupled with the severe maternal and child health problems, it is understandable that increasing the use of birth spacing has become a national priority. The Ministry of Health and its partners support a broad range of activities designed to provide birth spacing services to women of reproductive age. These activities include: upgrading government family planning services at health centers; outreach by health center staff; subsidizing non-government family planning clinics; supporting community based distribution systems; funding the social marketing of pills and condoms; incorporating birth spacing into general health promotion programs; integrating family planning services with village health, water and sanitation programs, and training medical staff to provide sterilization services at provincial hospitals.

These efforts are making gradual progress. Comparing survey results from 1995 to 1998 suggests that knowledge about modern methods has increased substantially – from 36 percent to 73 percent. Similarly, the CPR for modern methods was estimated at only 7 percent in 1995, compared to the more recent estimate of 16 percent nationwide.[1]

While these activities work toward increasing contraceptive prevalence, the progress made is eroded by high dropout rates among users of modern birth spacing methods. Sound estimates of the dropout rates are not available, but various surveys and qualitative studies suggest that dropout of hormonal methods is problematic.[2] Two major reasons that have been identified for discontinuing use are side effects and complications resulting from hormonal contraceptives. The 1995 KAP Survey estimated that 45 percent of those who discontinued modern method use did so for these reasons.

---

[1] From the 1995 KAP Survey on Fertility and Contraception in Cambodia, and the 1998 National Health Survey. These statistics should be viewed as merely indicative of the magnitude of change since they are based on different sampling methods and different samples of women.

[2] For example, see Women's Preferences and Experiences with Modern Contraceptive Technologies in Cambodia, 1996; and Cambodian Women's Perceptions of Fertility and Contraception, 1994.

While the side-effects of oral contraceptives and injectables are well known, dropouts reflects the lack of access to reliable birth spacing services and appropriate counseling.

## 3. Reasons for Discontinuing Birth Spacing

Recent qualitative studies have explored various issues concerning Cambodian women's perceptions and attitudes regarding fertility and modern contraception technologies.[3] A fairly clear picture emerges from this work that describes why women would choose to discontinue use of a hormonal method.

Women initially regard the effectiveness of the contraceptive as the most important criterion in deciding to use it. Later, suitability of the method reflected in the experience of side effects becomes equally important, resulting in switching methods or discontinuing entirely. Women with three or more children often decide to use a contraceptive not to space their pregnancies, but to limit or stop conception until menopause. They simply want no more children.

Rural women with very little or no formal education adapt traditional concepts of health, human anatomy, and the general workings of the body to understand modern contraceptives and their effectiveness in preventing pregnancy.[4] For conception to occur, the four basic elements of the body – air, earth, wind and fire - must be in balance. The body of the women must be "cool". Both oral and injectable contraceptives are viewed as very strong agents that have a "heating" effect on the womb that prevents conception. In effect, these contraceptives throw the fire element "out of balance".

However, the heating effect of pills and injectables are not identical. Injections heat in a way that can melt or wither (to dry up) the womb. As a result, injectables are believed to induce a state equivalent to early menopause reflected in the common side effect of amenorrhea that often occurs in the first few months after beginning this method. In this traditional interpretation, women do not menstruate because the injectable has withered their womb. The strong heating effect of injectables affects the blood's thickness, resulting in spotting or hemorrhaging, again common during the first months of use. The heating action of oral contraceptives also affect the blood's thickness, but pills are seen as drying out the body, especially the skin, which it drys and causes to darken.

The suitability or appropriateness (*trew*) of a contraceptive method is highly individualistic. What works well for me might not work at all well for you. The contraceptive is seen as fitting or not fitting with one's body. A method that is deemed

---

[3] Ibid.

[4] Gross generalizations that all or a large majority of rural women think one way or another is a distortion that should be avoided. To what extent traditional concepts are applied to modern technologies and conditions now in Cambodia while it is undergoing an explosion of exposure to outside information and communication is anyone's guess. It is worth noting that some women simply state that they have no idea why contraceptives are so effective, they just use them because they are so. "I don't know" is probably indicative of many users.

inappropriate for the user is discontinued in many cases. However, the views and opinions of others, especially regarding the meaning of side effects the user experiences, do influence decisions about continuing or discontinuing use.

The heating effects of pills and injectables also account for the side effects women often experience from using hormonal contraceptives. While weight gain attributed to use of contraceptives is generally a good effect in that this is considered a sign of health, wealth and beauty. However, too much weight gain can interfere in the woman's ability to work hard - a bad effect. Most other side effects are viewed negatively. The imbalance in the body's elements can result in poor health. The heating of blood by contraceptives can thicken it, forming lumps that can lead to tumors or cancer. The absence of menstruation, or changes in the volume of blood, that result from these contraceptives is worrisome. "What happens to all that blood that did not come out" is a concern expressed by some women. Others report that they feel hot all the time while using contraceptives.

For many rural women avoiding expenditures is an end in itself, even if it jeopardizes their health. For these women, side effects that interfere with their ability to work hard every day are among the most unacceptable. This is understandable – these women are by and large farmers who have to be able to work long hours daily. They are also poor and lack convenient access to follow-up services and counseling regarding the side effects they are experiencing. Some women view side effects that interfere with work as something that a rich woman can tolerate because she can afford follow-up services and does not have to work hard. In addition to service cost issues, some women report that contraception still carries a social stigma in the villages; a women who experiences side effects deserves these problems because she uses birth spacing.

It is also important to recognize that taking pills or using injectables becomes a convenient "catch-all" explanation for various physical problems. In effect, everything can be construed as a side effect of the contraceptive. Compounding the problem of side effects is that a number of physical problems women associate with contraceptives are very likely symptoms of reproductive tract infections. This includes painful urination, burning sensations in the upper or lower reproductive tract, pains in the pelvic area and heavy vaginal discharges. Women using hormonal contraceptives readily attribute these problems to their method and do not understand that the cause lies elsewhere.

In summary, the cost of follow-up care in managing or responding to side effects, the lack of access to affordable birth-spacing services, the inability to work hard as a result of side effects (real or imaginary), association of various physical problems with using a contraceptive, and social stigma lead to low tolerance of side effects that results in dropouts s among rural women. This is especially true for younger women who have not yet had their desired number of children and for those not highly motivated to space or limit pregnancies.

## 4. Methodology

Five health centers were purposively selected to reduce logistical requirements for the survey. The five health centers collectively provide services to 106 villages. Current Ministry of Health definitions of "late" versus "drop-out" (i.e., discontinuing) clients were used to identify the sample. A "late" pill user is a client who is more than one week past her scheduled return to the health center for her next cycle(s) of pills. A "late" injectable user is a client who is more than two weeks past her scheduled visit for her next injection. These clients remain "late" up to three months past their last scheduled visit. After three months, clients are then considered to be "drop-outs"- i.e., they have discontinued use of birth spacing services from the health center.

Following these definitions, the health centers' registers were used to identify 25 late clients and 25 drop-out clients for each facility, giving a total sample of 250 women. Time, budget constraints, and program needs precluded using a more statistically rigorous sampling method.[5] RACHA developed and field tested the questionnaires for late and drop-out clients.[6] Late clients who came to the health center during the survey were interviewed by the midwife present that day. Most were interviewed at home, as were all drop-out clients. Locating the clients for interviewing proved challenging and, in some cases, impossible. Some women did not want anyone in their village knowing that they were using birth spacing and gave health center staff false names and addresses to hide their identity. Replacement clients were identified for those who could not be located. Others were simply busy with their daily work routine and required repeated visits to interview.

The Ministry of Women's Affairs (MWA) provided five volunteer interviewers who RACHA trained and supervised. They were paid a nominal fee per completed interview to provide an incentive and to cover their transportation costs. None of the sampled women refused to be interviewed. RACHA's survey supervisor also conducted 27 in-depth qualitative interviews with selected clients. Annex B contains lists of the five health centers included in the survey and the villages within their catchment areas.

## 5. The Sample

The sample consists of 125 late clients and 125 drop-out clients. Within the late client group, 43 clients were pill users and 82 were injectable users, reflecting the strong preference for the latter method. Among the drop-out clients, 45 used the pill and 80 used the injectable, suggesting the preference for injectable to pills is about two to one. The following table presents some descriptive information about the women in the sample and their families.

---

[5] In a formal sense, this is not a statistically representative sample - no random selection process was followed to select the health centers or to select clients for interviews. How representative these data are other locations in Cambodia is unknown. However, 250 cases is sufficient to provide a general description of factors influencing the behavior of women resulting in being a late or drop-out client.

[6] Copies are attached in Annex A

**Table 1: Characteristics of Late, Drop-out, Pills and Injectables Clients**

| Variable | Late | Drop-out | Pills | Injectables |
|---|---|---|---|---|
| **Average Age** | 33 | 32 | 31 | 33 |
| **Number of Children** | 3.8 | 3.3 | 2.9 | 3.9 |
| **Average Age of Youngest Child** (months) **Number** | 45 | 42 | 42 | 43 |
| Percent of children <=1 years | 16 | 9 | 18 | 12 |
| Percent of children >1 <=2 | 23 | 27 | 24 | 25 |
| Percent of children >2 <=3 | 14 | 21 | 13 | 19 |
| Percent of children >3 <=4 | 15 | 17 | 17 | 16 |
| Percent of children >4 <=5 | 11 | 15 | 13 | 12 |
| Percent of children >5 years | 21 | 11 | 16 | 16 |
| **Travel time (minutes) to health center:** Bicycle | 34 | 14 | 27 | 35 |
| Motorcycle | 15 | 31 | 12 | 17 |
| Walking | 28 | 17 | 16 | 25 |

The average age of women in this sample corresponds to what other recent surveys have found when they take a cross-section of married women of reproductive age. Generally the average age is around 30, so that if the sample is organized by late versus drop-out or by method, late clients and injectable users are a bit older on average. Similarly, late clients and injectable users have a more children, 3.8 and 3.9 respectively. Pill users have the fewest children with 2.9 on average.

The age of the youngest child is also shown in Table 1. However, the number of children in each group is small and little in the way of firm conclusions can be made.

Distance from the health center is important with respect to access to services. When pill users are compared to injectable users, the latter are clearly located farther away from the health centers than are pill users. Travel times for injectable users are all greater than those for pill users. Given the difficulty of travel during several months each year, injectables clearly have an advantage over pills for women living in more remote areas.

***(Chris, any idea why it is almost consistently more time if they use a bike than if they walk? Also, motos take longer than bikes or walking for drop-outs)***

One important characteristic that needs to be kept in mind is that all of these women are atypical in their use of health center services. Most rural villagers do not use the services of health centers for various reasons including unfamiliarity with the health centers, their staff and services; negative perceptions regarding poor service quality and the lack of drugs from personal experience and reports by others; expectations that the cost of services will be excessive; established health seeking behaviors that do not include use of health centers except for extreme illness; and simply the difficulty, time and cost of traveling to the health center especially during the wet season and peak labor times for farmers. All of the women in this sample differ from most other rural women in that they are or were making use of their local health center for birth spacing services. Moreover, in light of the low contraceptive prevalence in rural Cambodia, the fact that these women were using birth spacing also distinguishes them from other rural women.

## 6. Findings

The results from surveying women who had discontinued use or dropped out is presented first. Findings from the two groups of women do not differ markedly. The reader's attention will be drawn to the differences when they occur.

### 6.1 Drop-out Clients

In this portion of the survey, 125 drop-out clients identified from health center records were interviewed; this included 45 pill users and 80 injectable users. The first set of questions concerned the duration of use of the method, expectations regarding the long-term effects of the method on the user's health, and experience with side effects.

As shown in Table 2, a very large percentage of drop-out clients - 77 percent (combined 46+31) - used their method for less than one year, while a comparatively small percentage - 22 percent used their method for more than one year, and only 12 percent for more than two years. These results indicate that a majority of the women in this sample tried a method briefly, and then within a year discontinued use.

A higher percentage of pill users than injectable users reported that they do not anticipate any long-term adverse affects on their health from use of their former birth spacing method. However, a much higher percentage of injectable users - 27 percent - reported that they expect to have a problem affecting the uterus or cervix compared to a much lower percentage of pill users - only nine percent. Next most frequently cited - problems, weight loss and pregnancy complications - as well as the less frequently mentioned effects, largely correspond to the results obtained for late clients (see Table 14). Anxiety about many of these expected long-term effects could be resolved by more effective counseling during birth spacing services.

**Table 2: Duration of Use, Expected Effects, and Side Effects – Dropout Clients**

| Variable | Pills % | Injectables % | Combined % |
|---|---|---|---|
| **Duration of method use:** < 6 months | 56 | 41 | 46 |
| > 6 < 12 months | 24 | 35 | 31 |
| > 12 < 24 months | 7 | 13 | 10 |
| > 24 months | 13 | 11 | 12 |
| **Expected long-term effects on health:** | | | |
| None | 39 | 31 | 34 |
| Problem affecting uterus or cervix | 9 | 27 | 23 |
| Incurable disease | 11 | 12 | 12 |
| Weight loss | 15 | 9 | 11 |
| Pregnancy complications | 11 | 10 | 10 |
| Menstruation problems | 0 | 4 | 3 |
| Vaginal bleeding | 2 | 3 | 3 |
| Make sterile | 6 | 1 | 3 |
| Other | 0 | 2 | 1 |
| Don't know | 0 | 2 | 1 |
| **Percent who experienced side-effects** | 73 | 84 | 80 |
| Trembling, palpation, fatigue, appetite loss, loss of weight | 35 | 32 | 33 |
| High temperature, feel hot | 16 | 12 | 13 |
| Headache, nausea, vomiting, vertigo | 22 | 8 | 13 |
| Vaginal bleeding problems | 4 | 15 | 11 |
| Menstruation ceased or painful | 3 | 15 | 11 |
| Felt cold | 9 | 3 | 5 |
| Neck tenderness | 0 | 3 | 3 |
| Weight gain | 2 | 3 | 2 |
| Caused problems for the child | 2 | 3 | 2 |
| Slight temperature | 4 | 1 | 2 |
| Muscle, chest, abdominal pain | 5 | 2 | 2 |
| Other | 2 | 2 | 3 |

The results show that a higher percentage of drop-out clients - 80 percent overall - reported that they experienced side effects than did late clients - 64 percent overall. This may mean that drop-out clients either experienced somewhat more severe side effects or they had a lower level of acceptance or tolerance for side effects than late clients (see Table 15). As a result, they decide to discontinue their former method as opposed to late clients, a majority of whom (79 percent overall) reported that they plan to continue using their current method despite experiencing side effects.

The most frequently cited side effects are: trembling/palpitations/fatigue/appetite loss/weight loss. The next three most common side effects reported by drop-out clients are high temperature/feel hot, headache/nausea/vomiting/dizziness, and vaginal bleeding

problems. These top four leading types of side effects account for 70 percent of the responses from drop-out clients and 77 percent for late clients (see Table 15). The remainder of side effects cited by drop-out clients are distributed in small percentages across various other problems, comparable to those reported by late clients.

The results in Table 3 show that a very high percentage of drop-out clients not only discontinued using the method they had been obtaining from the health center, but discontinued birth spacing entirely. Overall, 90 percent of drop-out clients reported that they discontinued their former method and 82 percent were currently not using an alternative birth spacing method when they were interviewed. This means that only 18 percent of the women in this sample of drop-out clients switched to an alternative method or source of supply after discontinuing using health center birth spacing services.

The large majority of women who discontinued their former method - 84 percent overall - decided to do so on their own. That percentage increases to 91 percent if the woman and her husband/partner are considered. Only five percent reported that the decision to discontinue was made solely by the woman's husband/partner**.** In other words, among the drop-out clients in this sample, the decision to discontinue use was overwhelming made the client herself, and, in only a few cases, was the decision made by someone else.

**Table 3: Dropouts s from Previous Method**

| Variable | Pills % | Injectable % | Combined % |
|---|---|---|---|
| **Women who stopped using the method** | 87 | 91 | 90 |
| **Women not using a different method now** | 77 | 85 | 82 |
| **Who made the decision to stop:** | | | |
| Woman herself | 84 | 86 | 84 |
| Husband/partner only | 5 | 4 | 5 |
| Woman and her husband/partner | 7 | 4 | 7 |
| Woman and health center staff | 1 | 1 | 1 |
| Other | 3 | 4 | 3 |

Drop-out clients most frequently reported that side effects (see Table 4) were a major reason for discontinuing; 27 percent overall cited side effects as a factor influencing their decision. Injectable users cited side effects as a reason for discontinuing more frequently than pill users - 32 versus 19 percent. If other physical symptoms that respondents defined as side effects (but could not be due to the contraceptive) and fear of experiencing side effects are included, 35 percent of the responses given by this sample of drop-out clients are associated with actual or imputed side effects of the method.

The next three most common reasons for discontinuing - fear of long-term effects on health, wanted to have a baby, and too busy - account for another 40 percent of the responses. It is interesting to note that pill users reported wanting to have a baby almost twice as frequently as injectable users (19 versus 10 percent) and that they were "too busy" more frequently than injectable users. First, women who anticipate having a child in the near future might tend to prefer pills over injectables because pills can be more quickly terminated. Second, more frequent visits to the health center for monthly pill renewals might contribute to the higher percentage of pill users being "too busy".

**Table 4: Reasons for Dropping Out**

| Reasons for Discontinuing Method | Pills % | Injectables % | Combined % |
|---|---|---|---|
| Experienced side-effects | 19 | 32 | 27 |
| Afraid of effects on health | 14 | 17 | 16 |
| Wanted to get pregnant | 19 | 10 | 13 |
| Too busy | 14 | 9 | 11 |
| Imaginary side-effects | 7 | 6 | 7 |
| Waiting until next period to start | 0 | 7 | 5 |
| Too difficult to obtain | 7 | 2 | 3 |
| Fear of side-effects | 2 | 1 | 1 |
| Felt embarrassed at health center | 2 | 0 | 1 |
| Forgot to go to the health center | 0 | 2 | 1 |
| Wanted to try another method | 2 | 1 | 1 |
| Health problems | 0 | 1 | 1 |
| Too much trouble to use | 2 | 2 | 1 |
| Other | 15 | 13 | 13 |

Reasons for discontinuing can be viewed as actual/imputed/anticipated side effects versus life-style fit (fear of health effects, wanted to have a baby, too busy, too difficult, forgot, embarrassed, too much trouble to use). Grouped this way, 35 percent of the reasons given by this sample of women pertain to physical side effects versus 46 percent that are in some way related to life style considerations. This means that dropout decisions are principally influenced by both side effects and life style considerations.

This has important implications for improving birth spacing services. Better information and assistance concerning side effects will certainly be important, but taking into consideration the fit between the method's requirement and the client's daily routine (life style) will be is equally important. Central to the life style issue is the accessibility of services to the client when she needs them, and the costs - time and money - the client encounters in gaining access to those services.

It is interesting to note that no one in the survey - late and drop-out clients - cited the cost of service for pills or injections was a reason for them discontinuing. Drop-out clients were specifically questioned about cost to see whether this might be a factor in deciding to discontinue. The results are very revealing.

**Table 5: Average Cost of Method – Dropout Clients**

| | Pills | Injectable |
|---|---|---|
| **Average cost of pills per cycle and average cost per injection** | R584 | R989 |
| $US at R3800 = $1 | 0.15 | 0.26 |

The cost of one cycle of pills posted at health centers is R500; one injection is posted at R1,500. What the survey data show is considerable variation in actual charges from these posted rates. The average cost of services reported by the sample of former users is R584 for pills, and R989 for injections. The following table shows the reported distribution of costs.

**Table 6: Distribution of Costs Experienced – Dropout Clients**

| Cost | Number of Clients | Percentage |
|---|---|---|
| **Pills (3 cycles)** | | |
| R500 | 7 | 16 |
| R1,000 | 6 | 13 |
| R1,300 | 1 | 2 |
| R1,500 | 26 | 58 |
| R2,000 | 5 | 11 |
| **Injectables (1 injection)** | | |
| 0 | 1 | 1 |
| R500 | 27 | 34 |
| R1,000 | 26 | 33 |
| R1,300 | 2 | 3 |
| R1,500 | 24 | 30 |

The frequency distribution of payments in Table 6 shows considerable variation in what clients actually pay versus posted prices in the health clinics. For three cycles of pills, only 24 out of 45 (58 percent) former pill users paid the actual posted price of R1,500, while five clients reported paying as much as R2,000. This might constitute an "under the table" payment that is believed to occur frequently at health centers. The remainder - 14 out of the 45 pill users in this sample - paid less than R1,500. Charging less to those who health center staff believe cannot afford the full price is a permitted practice. For injectable clients, only 24 out of 80 users in this sample, or 30 percent, paid the full cost of R1,500 for their injection. Many paid either R500 or R1,000 (67 percent), while one client received her injection for free and two paid slightly below the posted price.

The data also show that a greater percentage of injectable users received services at below posted rates (70 percent paid less than R1,500) than did pills users (only 31 percent). Furthermore, no injectable users paid more than the posted price as opposed to 11 percent of pill users. If this is a widespread, on-going practice, such discounts that essentially subsidize the use of a method could have the effect of promoting the use of injectables over pills.

These results suggest that the cost of birth spacing use for the same period of time was, on average considerably higher for pill users - three months of pills cost R1752 on average versus the R989 for an injection effective for the same period of time. While the absolute cost of pills is higher, spreading costs over time might make this more appealing or manageable for some clients. That is, some women might be able to afford R584 each month for pills, but they might not be able to afford R989 at one time for the injection. This is something that warrants further study to determine whether costs and payments over time might promote greater use of birth spacing among poor rural women.

The data show that 19 percent of pill users and 10 percent of injectable users reported that their desire to have another child was a factor in their decision to discontinue their method. As shown in Table 7, when asked when they would like to have their next child, 50 percent of drop-out clients overall are not interested in having another child. Injectable users were less interested in having another child than pill users - 58 percent versus 38 percent. This desire to stop childbearing conflicts sharply with findings showing that the large majority of women in this sample - 82 percent - who discontinued their method did not switch to another method or source, but stopped birth spacing entirely.

**Table 7: Desire to have Another Child – Dropout Clients**

| When the Next Child is Wanted | Pills | Injectable | Combined |
|---|---|---|---|
| Not interested in having another child | 38 | 58 | 50 |
| Within 2 years | 22 | 18 | 19 |
| More than 2 years | 24 | 8 | 14 |
| Don't know | 16 | 18 | 17 |

Pill users as a group tended to be more interested in having at least one more child. Among pill users, 46 percent reported that would like to have another child either within two years or longer (22+24), compared to only 26 percent of injectable users. This suggests that injectables are preferred by a somewhat higher percentage of woman in this sample to prevent all future pregnancies. An equivalent percentage of pill and injectable users reported that they are unsure about when they will have another child.

There is reason to believe that the women who had been using injectables are candidates for longer-term methods. It is possible to assume that these women might be

interested in using IUDs, if quality services and counseling were available. And, quite possibly, some of these women with many children or older in age would be interested in sterilization. As has been stated many times in this report, a major issue in increasing contraceptive use is access. "Access" as used here, includes both availability and appropriate counseling and support to couples who choose to space or limit child bearing.

An encouraging finding (Table 8) is that a large majority of drop-out clients - 88 percent overall - reported that they plan to use birth spacing again sometime in the future, and former pill users plan to do so somewhat more than injectable users - 93 percent versus 82 percent.

Plans as to when they will start again fall into two general categories: "after childbearing" (i.e., after having another child, after her current pregnancy, after weaning the baby) and "after the current interruption" in use (i.e., after next menstruation, in one to eight months, very soon, when husband returns, when she feels better). This latter category is also described in other studies - women will stop birth spacing for a period of time for various reasons other than to have another child. This includes being free of side effects for a while, being too busy to obtain services during a peak work period of the year, and having a regular menstrual cycle for a while.

**Table 8: Future Use of Birth Spacing – Dropout Clients**

| Variable | Pills % | Injectable % | Combined % |
|---|---|---|---|
| **Women who plan to use birth spacing again** | 93 | 82 | 88 |
| **When the woman will start using again:** | | | |
| After next menstruation | 25 | 23 | 24 |
| After having another child | 25 | 19 | 21 |
| In 1-8 months | 14 | 13 | 12 |
| After current pregnancy | 14 | 10 | 10 |
| Tomorrow/very soon | 7 | 8 | 9 |
| Wait until next year/after weaning the baby | 7 | 8 | 7 |
| After husband returns home | 4 | 6 | 5 |
| When more 30 years old | 4 | 2 | 3 |
| When she feels better | 0 | 2 | 1 |
| Don't know | 4 | 11 | 9 |

If responses are grouped accordingly, "after child bearing" accounts for 38 percent of the responses, while "after the current interruption" accounts for 51 percent, or 89 percent overall.

When women were asked which method they will use when they start again, 75 percent of pill users and 70 percent of injectable users stated that they plan to use their

former method again. This indicataes that whatever factors associated with their former method contributed to dropping out, these problems or difficulties are not perceived to be so great as to discourage many from using the same method again.

The data also show that some women plan to switch to the major alternative method - 14 percent of former pill users think that they will try the injectable, while 21 percent of former injectable users think they will try the pill. Interestingly, while no former injectable users plan to be sterilized, four percent of former pill users report they will do so. However, since knowledge of sterilization is almost non-existent, these responses need to be placed in that context. A small percentage are unsure about which method they will use in the future.

**Table 9: Method Preference for Next Use of Birth Spacing – Dropout Clients**

| Variable | Pills % | Injectable % | Combined % |
|---|---|---|---|
| **Method preference for next time woman uses birth spacing:** | | | |
| Pill | 75 | 21 | 40 |
| Injectable | 14 | 70 | 51 |
| Sterilization | 4 | 0 | 1 |
| Condom | 0 | 4 | 3 |
| Don't know | 7 | 6 | 6 |
| **Reason for choosing that method:** | | | |
| Easy to use | 34 | 65 | 54 |
| Regular menstruation | 16 | 9 | 11 |
| Want to try it | 9 | 12 | 11 |
| Less side effects | 22 | 0 | 8 |
| Used it before, no side effects | 9 | 5 | 7 |
| No effect on health | 3 | 4 | 3 |
| No drugs, use condom when having sex | 0 | 4 | 2 |
| Other | 6 | 2 | 3 |

The reasons for selecting their next method are quite different between former pill and former injectable users. The majority of former injectable users cited three main reasons - easy to use (65 percent), regular menstruation (nine percent), and want to try it (an alternative method - 12 percent) - that account for 86 percent of the reasons this group stated. Pill users were more diversified across five reasons - easy to use (34 percent), regular menstruation (16 percent), want to try it (nine percent), less side effects (22 percent) and used before/no side effects (nine percent) that account 90 percent of their responses. For the women in this sample, the pill seems to have been particularly attractive compared to injectables because of the general perception that there are fewer side effects with the pill, while the appeal of injectables stems from ease of use.

Drop-out clients were asked about other methods they had ever used (i.e., other than the method they had discontinued that identified them for the survey). Overall, 67

percent of respondents have never used a birth spacing method other than the one she had just discontinued using. In others, many of these women are first time users of modern contraceptives. Predictably, some former pill users had tried injectables, and some former injectables users had taken the pill during previous periods of birth spacing. Some eight percent of drop-out clients had used the Chinese (once a month) pill, while the balance of methods were only by small numbers of these women.

**Table 10: Experience with Other Methods – Dropout Clients**

| Variable | Pills % | Injectable % | Combined % |
|---|---|---|---|
| **Other methods that the woman has used:** | | | |
| None | 60 | 71 | 67 |
| Pill | 0 | 16 | 10 |
| Injectable | 17 | 0 | 6 |
| Chinese Pill | 9 | 7 | 8 |
| Condom | 6 | 4 | 5 |
| Calendar | 4 | 2 | 3 |
| IUD | 2 | 0 | 1 |
| Withdrawal | 2 | 0 | 1 |

Drop-out clients were asked to assess the quality of services they received, and an overwhelmingly positive sets of responses were obtained (see similar response for late clients in Table 20). The responses to this question reflects, we believe, as much if not more cultural values of rural women than actual service quality.

**Table 11: Health Center Service Quality – Dropout Clients**

| Variable | Pills % | Injectable % | Combined % |
|---|---|---|---|
| **Women satisfied with birth spacing services at the health center** | 100 | 98 | 98 |
| **Behavior of health center staff:** | | | |
| Courteous | 98 | 96 | 97 |
| Helpful | 2 | 1 | 2 |
| Impolite | 0 | 3 | 2 |
| **Women who reported that the provider answered all of her questions** | 99 | 100 | 99 |

### 6.2 Late Client Results

We are aware that some "late clients" will become drop-outs merely by extending their lateness to the three month mark that defines a dropout . Nevertheless, it was believed that some of the issues that were causing late clients to be late might be unique to this group or that insights to improving the birth spacing program might be gained by interviewing these women. Many of the questions asked of drop-outs were also asked of late clients, but there are a few that are different for late clients. As will be seen in the following results, many of the findings confirm conclusions already made in the preceding section.

Late clients were asked whether they ever missed a day during their last cycle of pills or were ever late for their next scheduled injection. Little difference in compliance was found between methods.

**Table 12: Late Pill and Injectable Clients - Late or Missed Days – Late Clients**

| Compliance in Using Method | Percentage |
|---|---|
| **Clients who did not miss a day/pill during their last cycle** | 84 |
| **Clients who have never been late before for next injection** | 88 |

A fairly high percentage of pill and injectable clients report fairly consistent compliance with the schedule of their method. Of the seven woman who reported missing days during the last cycle, four women failed to take pills for only one day, one woman missed two days, one missed exactly five days, and one reported she missed more than five days. Among injectable clients, of the nine women who reported having been late for their scheduled injection in the past, three could not remember how late they had been; one reported being late by only two days, and five women reported being from 15 to 30 days late. This suggests that failing to comply with their birth spacing method is common problem when the women were still committed to using birth spacing.

When asked about the reasons for being late (Table 13) for their next scheduled visit to the health center, little significant difference was found between pill and injectable users. The top five most frequently cited reasons account for 69 percent of the responses from pill users and 72 percent of responses from injectable users. The two main reasons cited are "too busy" and "experienced side effects".

In-depth interviews confirm that the response "too busy" is indeed a true statement accounting for the client being late for services and should not be viewed as

merely a convenient way to account for being late. For example, one woman who sells fish in the local market in the morning reported that by the time she is finished, the health center is closed and staff are long gone. For her to obtain services, she would have to stop her business for a day, something she cannot afford to do. In this example, "too busy" refers to inadequate access to services due to the abbreviated working hours of the health center staff.

**Table 13: Reasons for Being Late – Late Clients**

| Reasons | Pill % | Injectable % | Combined % |
|---|---|---|---|
| Too busy | 31 | 27 | 28 |
| Experienced side effects | 16 | 20 | 18 |
| Afraid of effect on health | 8 | 9 | 9 |
| Forgot to go to the health center | 8 | 9 | 9 |
| Too difficult to obtain | 6 | 8 | 8 |
| Would like to get pregnant | 8 | 4 | 5 |
| Waiting for her next period | 2 | 5 | 4 |
| Embarrassed visiting the health center | 5 | 2 | 3 |
| Fear of side effects | 3 | 2 | 3 |
| Had a health problem | 3 | 2 | 2 |
| Wanted to try another method | 0 | 2 | 2 |
| Imaginary side effects | 3 | 2 | 2 |
| Husband objected to birth spacing | 0 | 1 | 1 |
| Other* | 8 | 8 | 8 |

(* Other includes various statements cited by only one woman)

Another woman is a farmer who depends on the labor of her neighbors during peak work times - plowing, planting, harvesting. In turn, she must assist her neighbors who help her - this a very common practice used to meet farm labor requirements that exceed an individual household's manpower. She reports that she is genuinely too busy at these times to go to the health center to obtain birth spacing services when scheduled. Again, the problem is a lack of access - if the client cannot come to the health center, then birth spacing services and supplies need to be offered as part of outreach, and those visits must occur regularly.

As preceding studies have shown, side effects are a major problem associated with dropout from hormonal birth spacing methods. Among pill users, 16 percent of respondents reported that side effects accounted for being late, while 20 percent reported the same among injectable users. If we add to this the fear of side effects (not yet experienced) and other effects the women attribute to the contraceptive but are not actual side effects of a contraceptive (e.g., imaginary effects) these percentages increase to 24 percent for both methods.[7] While side effects are a common problem for hormonal

[7] Imaginary effects include various responses that attribute all sorts of problems to the use of the contraceptive. Examples include pain running from the hip to the ankle, endless gaining of weight, causing a breastfeeding child to be thin or to have a fever, and losing sexual sensation.

method users, the lack of easy access to services and counseling compounds the situation. As in-depth interviews confirmed, the time and costs involved with making follow-up visits to health centers to get assistance for side effects discourages many women, especially during the busy times of the year.

In addition to side effects, fear of long-term effects on health, forgetting to go to the health center, too difficult to obtain, and wanting to have another baby are cited by women as reasons for their being late. These responses suggest is that some late clients are, in fact, "early" drop-out cases, or potential drop-outs in the making. That is, within this group of women are some who will subsequently continue birth spacing, while others has already decided to discontinue or were in the process of doing so when they were interviewed.[8] Consequently, following MoH definitions results in a sample of late clients that combine women who are actually just late with those who have actually decided to discontinue birth spacing.

It is interesting to note that very few women said that they were late because they were embarrassed by going to the health center (only six out of 125) or that their husbands objected (only one). This suggests that, at least among this sample of women, being late is not due to widespread embarrassment in obtain birth spacing services from the health center, or pressure at home to stop birth spacing.[9]

Another way to view reasons for being late (and for discontinuing, as will be seen later) is to group them as two broad categories. One category is adverse physiological reactions to the contraceptive; the other could be described as "life style fit". The latter includes such reasons as being too busy, too difficult to obtain services, and even wanting to have another baby. Part of this results from the woman's own need to earn a living, while other elements of the "life style fit" problem stem directly from the inadequate access to birth spacing services. This includes the brief working hours of health centers only in the morning, irregular outreach services that may or may not offer birth spacing services, and staff who are poorly trained or unable to provide correct counseling on alternative methods and side effects.

When reasons for being late are categorized accordingly, about 40 percent of the reasons refer to physiological effects (combining actual, anticipated and imaginary side effects) and about 45 percent pertain to the method not fitting easily with the client's life style.

---

These effects are typically made by only one or two women and have been grouped as imaginary effects for presentation purposes.

[8] This raises a question as to whether the MoH's definition of "late" clients is realistic, e.g., is a woman who is one or two months past her scheduled visit just late or has she dropped-out? Perhaps the "late" time frame needs to be revised to reflect what is actually happening.

[9] A several of women in the in-depth interviews did say they would be embarrassed if their neighbors knew they used birth spacing or that their husband had objected. Interestingly, two women who said their husbands objected said they continued to use birth spacing secretly without the husband's knowledge.

When women were asked about their expectations regarding the long-term effects of their method on their health, 44 percent of pill users reported that they believed that there would be no negative health effects, compared to only 30 percent of injectable users. The application of traditional concepts about the body and health to hormonal contraceptives might account for this difference. Information from the in-depth interviews and other qualitative studies have found that women believe that injectables are very strong and have a powerful "heating" effect on the body, particularly the uterus. They assume, therefore, that such a strong drug that is taken once and is effective for three months is more likely to have negative, long-term effects on their health than the pill that must be taken daily and is effective for a much briefer period of time.

**Table 14: Expected Long-term Effects on Health – Late Clients**

| Expected Effects | Pills % | Injectable % | Combined % |
|---|---|---|---|
| None | 44 | 30 | 35 |
| Problem affecting uterus or cervix | 22 | 19 | 20 |
| Weight loss | 8 | 11 | 10 |
| Incurable disease | 8 | 6 | 7 |
| Vaginal bleeding | 4 | 6 | 5 |
| Complications with pregnancy | 4 | 8 | 7 |
| Weight gain | 0 | 6 | 4 |
| Menstruation ceases | 0 | 4 | 3 |
| Other | 11 | 6 | 8 |
| Don't know | 0 | 3 | 2 |

While these data do not address such cultural interpretations, the results do suggest the need for better counseling about the nature and risk of adverse long-term effects of hormonal contraceptives. Ideas that the contraceptive will cause incurable diseases, that "hairy blood clots" will form in their uterus, that they will become sterile and other misconceptions constitute unnecessary fears that could be reduced by effective counseling.

The second most common long-term effect late clients reported referred various problems affecting the uterus or cervix. This too is consistent with the common perception of hormonal contraceptives heating the body, especially the uterus. In this category, women cited the following effects: tumors in the abdomen or uterus, a blood clot (with hair) in the uterus, unspecified damage to the uterus or cervix, uterine cancer, inflammation of the cervix, and a fungus in the uterus.

Less frequently cited long-term effects were weight loss, unspecified incurable disease, vaginal bleeding, complications with future pregnancies (including the fetus being outside of the womb), weight gain, and end of menstruation. Effects cited by only

one or two women were grouped as “other”; this included: a blood clot will become fixed to the vertebrae, body trembling, hypertension, unspecified abdominal pain, swollen lungs, facial skin discoloration, fatigue, and sterilization.

As shown in Table 15, virtually the same percentage of pill and injectable users reported experiencing side effects - approximately two-thirds of all respondents. The four most frequently cited side effects account for 83 percent of all responses among pill users and 75 percent of responses by injectable users. The most common side-effects women experienced were trembling/palpitations/fatigue/appetite loss/weight loss. These experiences were cited partially or completely as an associated set of effects. The next common set of side effects included headache/ nausea/vomiting/dizziness, again cited by respondents as an associated set of effects. Somewhat less frequently reported were vaginal bleeding and high temperature. These side effects are common side effects many women experience, especially when first starting use of hormonal contraceptives.

**Table 15: Reported Side Effects – Late Clients**

| Side Effects | Pills % | Injectable % | Combined % |
|---|---|---|---|
| **Women who experienced side effects** | 63 | 65 | 64 |
| **Women reporting the following side effects:** | | | |
| Trembling/palpitations/fatigue/appetite loss/ | 44 | 26 | 32 |
| weight loss | 21 | 15 | 17 |
| Headache/nausea/vomiting/dizziness | 5 | 20 | 15 |
| Unusual vaginal bleeding | 13 | 14 | 13 |
| High temperature/felt hot | 5 | 5 | 5 |
| Felt cold | 0 | 6 | 4 |
| Slight temperature | 0 | 4 | 3 |
| Missed menstruation | 0 | 5 | 3 |
| Weight gain | 5 | 0 | 2 |
| Chest/abdominal pain | 0 | 2 | 2 |
| Neck tenderness | 7 | 2 | 3 |
| Other | | | |

The finding (see Table 16) that only one-third of late clients know when their next visit to the health center is for birth spacing services is an eye-opener. That would certainly make it difficult to be on-time. This suggests that much greater emphasis needs to be given to helping a client know when she should return for her next visit to the health center - again, better counseling is needed. Of those who did know when their next visit was, all pill users and most injectable users rely on their clinic card; relatively few women (only six out of 27 injectable users) use an alternative means for keeping track.

**Table16: Knowledge of Time for Next Visit – Late Clients**

| | Pills % | Injectable % | Combined % |
|---|---|---|---|
| **Women who know when their next visit for BS service is** | 35 | 33 | 34 |
| **How women who know when their next visit is remember the date:** | | | |
| Looks at her clinic card | 100 | 78 | 86 |
| Counts by the moon | | 11 | 7 |
| Marks the calendar | | 7 | 5 |
| Other | | 4 | 2 |

When asked what they like most about their chosen method (see Table 17), both pill users and injectable users most frequently reported the reduced fear of unwanted pregnancy.

With respect to ease of remembering when to use the method, a large difference is understandably found between pill and injectable users - 35 percent of injectable uses cited this factor in contrast to only two percent of pill users. Feeling better as a result of using their current method was mentioned by 11 percent of pill users and 14 percent of injectable users. Feeling better as a result of birth spacing is a broad, non-specific type of response that includes physical and psychological elements. Women who gained some weight - but not too much weight - as a result of using the pill or injectable might state that they feel better since some weight gain is often viewed positively, contributing to a woman's attractiveness. Women who have had very irregular menstrual periods might report feeling better as a result of having more regular periods due to the contraceptive. They might also feel better because they are less worry about unwanted pregnancies.

**Table 17: What Client Likes about Current Method -- Late Clients**

| Likes | Pills % | Injectables % | Combined % |
|---|---|---|---|
| Not afraid of becoming pregnant | 47 | 40 | 43 |
| Easy to remember | 2 | 35 | 23 |
| Method makes her feel better | 11 | 14 | 13 |
| Easy to swallow/use | 11 | 5 | 7 |
| Less side effects | 7 | 4 | 5 |
| Regular menstruation | 14 | 0 | 5 |
| Save time and money | 5 | 3 | 4 |
| No need for an injection | 4 | 0 | 1 |

The first three most frequently cited positive aspects account for 89 percent of the responses from injectable users, compared to only 60 percent for pill users. Various other "likes" were cited by pill users, particularly ease of use and having regular menstruation.

When asked about what they dislike about their method, a significant percentage of late clients - 38 percent of pill users and 40 percent injectable users - reported that they had no dislikes or problems. Dislikes reported by both groups tend to repeat side effects cited earlier - high temperature/feel cold/fatigue, body trembling, headache/nausea/ vomiting, and irregular or cessation of menstruation and weight gain among injectable users. In addition to these side effect, some pill users (five out of 47) disliked the difficulty of remembering to use this method.

**Table 18: What Client Dislikes about Current Method – Late Clients**

| Dislikes | Pills % | Injectables % | Combined % |
|---|---|---|---|
| Nothing | 38 | 40 | 39 |
| High temperature/feel cold/fatigue | 9 | 10 | 9 |
| Trembling body | 11 | 7 | 8 |
| Irregular menstruation | 0 | 11 | 7 |
| Feel uncomfortable sometimes | 6 | 7 | 7 |
| Weight gain | 0 | 8 | 6 |
| Headache/nausea/vomiting | 9 | 3 | 5 |
| No menstruation | 2 | 7 | 5 |
| Difficult to remember/count the days | 11 | 0 | 4 |
| Dislikes the injection | 0 | 4 | 3 |
| Fear about future effects on health | 2 | 2 | 2 |
| Chest/abdominal pain | 4 | 0 | 2 |
| Other | 6 | 2 | 4 |

An important finding (see Table 19) of the survey is that 80 percent of late clients are using a modern contraceptive for the first time - they report using no method other than their current method of pills or injectable. The balance who have used another method are distributed in small numbers among the other methods they cite. A small percentage are repeat users of their current method - two percent of pill and injectable users have used these methods before.

A relatively high percentage of both pill users (72 percent) and injectable users (83 percent) report that they want to continue using their method even though they are currently late in doing so. Of those who wanted to change their method, 50 percent of pill users wanted to use another method while only 29 percent of injectable users wanted to do so. The balance - six out of 43 pill users and 10 out of 82 injectable users - had decided to discontinue birth spacing. In other words, 13 percent of late clients in this sample had actually decided to discontinue at the time of the survey, and it is likely some more would also discontinue - either as a conscious decision or *de facto* - as they became progressively later in renewing their use.

**Table 19: Method Use and Pregnancy – Late Clients**

| Characteristics of Women | Pills % | Injectables % | Combined % |
|---|---|---|---|
| **Women who have ever used other methods:** | | | |
| Pills | 2 | 7 | 5 |
| Injectable | 7 | 2 | 4 |
| Chinese pill | 2 | 4 | 3 |
| Condom | 0 | 5 | 3 |
| IUD | 4 | 2 | 3 |
| Calendar | 4 | 0 | 2 |
| No other | 80 | 80 | 80 |
| **Women who want to continue present method** | 72 | 83 | 79 |
| **Those who do not want to continue, but want to try another method** | 50 | 29 | 39 |
| **When woman wants to have her next child:** | | | |
| Within two years | 14 | 6 | 9 |
| Wait more than two years | 9 | 9 | 9 |
| Does not want another one | 51 | 57 | 55 |
| Don't know | 26 | 28 | 27 |

A key factor influencing a woman's motivation to continue or discontinue birth spacing is her plans for having another child. When asked this question, 51 percent of pill users and 57 percent of injectable users reported that they do not want another child. This point was repeated by many of the respondents in the in-depth interviews and is consistent with informal interviews RACHA conducts with women. Those who have had three or four children typically use birth spacing not to space subsequent pregnancies, but to stop bearing children until they enter menopause. Clearly, it would be preferable for these women to consider IUDs or sterilization rather pills or injectables. But the in-depth interviews found that the majority of women either do not know how to stop having children and/or have not heard of tubal ligation. Those who have heard of the procedure reported they were afraid of rumored adverse effects or thought they could not afford it. Similar misconceptions discourage women from using IUDs as a longer-term method. In short, major changes in women's understanding of these methods will be needed before they will seriously consider IUDs and sterilization as options.

A significant percent (27 percent) reported that they are unsure about when they want to have another child. Nine percent of late clients reported that they want a child within two years, while another nine percent do not want another child for more than two years. In other words, the desire to have another child could account for approximately

nine percent of current pill and injectable users to discontinue birth spacing sometime within the next two years.

A final set of questions that late clients were asked concerned their assessment of the birth spacing service they received from health center staff. The findings were almost identical to the responses given by women who had become dropout s (see Table 11). The results were totally positive - 100 percent stated that the service provider was courteous and/or helpful, and all of their questions were answered. These results need to be understood in the proper context.[10] A more accurate interpretation of these responses is that whatever deficiencies in services the clients encountered were not so severe as to cause them to report them to a stranger - i.e., the interviewer. These results reflect the expectations and experiences of clients in obtaining health services as much if not more than the actual quality of those services. In other words, what they experienced in obtaining birth spacing services was to them not so bad, or so much out of ordinary, as to warrant being reported to the interviewer. That is not the same as saying that deficiencies do not exist and improvements are not needed. The preceding results strongly suggest the contrary - there is indeed much room for improvement.

**Table 20: Health Center Service Quality – Late Clients**

| | **Pills %** | **Injectables %** | **Combined %** |
|---|---|---|---|
| **Women who described the behavior of the service provider as courteous and/or helpful** | 100 | 100 | 100 |
| **Women reporting that the service provider answered all her questions** | 100 | 100 | 100 |

[10] The interpersonal dynamics involved in asking someone for their appraisal of a service is extremely complicated in rural villages. First, most villagers are not accustomed to being interviewed and asked what their opinion is. Second, it is extremely difficult to obtain candid appraisals of service quality in a structured interview setting. People are highly adverse to appearing to be critical in the presence of a stranger - the interviewer. This is generally considered extremely ill-mannered; and there is also concern that such criticism casts the respondent in a negative light. Some are also worried that criticism will somehow get back to the service provider and that could cause trouble for them in some way in the future. As the above results suggest, asking these questions is one thing, getting an accurate appraisal is indeed another matter.

# 7. Conclusions and Recommendations

Viewed as whole, results of the survey and in-depth interviews offer a composite picture of current birth spacing practices and behaviors among rural women, the main features of which include the following:

**Major Finding**

- Women who discontinued did so primarily because of side effects, time requirements - "too busy" - for obtaining services, or their decision to have another child.

- Many rural women who were using birth spacing were doing so for the first-time or were repeat "spacers," using the same method between pregnancies.

- Most women who were using pills or injectables had been doing so for less than one year.

- Most women experienced side effects from pills and injectables. The lack of readily accessible birth spacing services, particularly counseling, leads many women, especially younger women who have not yet had their desired number of children, to be intolerant of side effects.

- Many women who were late or drop-out clients were "too busy." "Too busy" reflects the very limited access to birth spacing services that rural women confront due to inadequacies in health center operations and weak staff skills, especially counseling.

- In addition to physical side effects that contribute to women being late or dropping out, an equally important set of factors was the fit between method requirements and the client's daily routine and work schedule - her life style.

- Some women who were late for their next re-supply of pills or next injection had either already decided, or were in the process of deciding, to discontinue use of that method temporarily or permanently.

- When women discontinued pills or injectables, the large majority of them did not switch to an alternative method.

- The large majority of women who discontinued decided to do so on their own. Someone else rarely made the decision, e.g., husbands, mothers or health center staff.

- The majority of late clients planned to continue using birth spacing and a very large majority of drop-out clients planned to use birth spacing again in the future.

- Approximately one third of women using pills or injectables did not expect these methods to have long-term adverse effects on their health. The majority of women who anticipated negative health effects had expectations that were based largely on misconceptions about hormonal contraceptives.

- Women using pills or injectables most valued the effectiveness of the contraceptive in preventing pregnancy and that it makes them feel better - physically and psychologically. Injectable users highly valued the ease of remembering correct method use, while pill users valued the fact they have a regular menstruation and the ease (convenience) of pill use.

- Approximately 40 percent of women using birth spacing expressed no dislikes of their method. What women did dislike were the side effects of hormonal contraceptives. Some pill users disliked the difficulty of remembering to take a pill daily, while some injectable users disliked the lack of regular menstruation.

- Only on third of women using birth spacing knew when their scheduled next visit was for pill re-supply or injection.

- Many women using pills or injectables were, in fact, not attempting to space their next pregnancy, but were trying to avoid pregnancy entirely. These women did not want another child; however, most were unaware of permanent or longer-term methods to prevent pregnancy.

- Many of those who had heard of tubal ligation were afraid of the procedure because of various misconceptions, or they thought that the cost of the procedure was prohibitive.

Despite the overwhelmingly positive answers to questions about birth spacing service quality, the information these women provided clearly point to the need for both more and better services. First, birth spacing services need to be made far more accessible than they currently are through longer operating hours at health centers, through more regular outreach visits to the villages, and through much greater provision of services by trained private providers. Second, the most important area in need of improvement is counseling. Better counseling initially about method options and potential side effects is needed. Counseling designed specifically to correct misconceptions about the potential effects of these methods on health is very clearly needed. Better counseling about managing side effects or changing methods to one that has fewer side effects and/or better fits the client's life style is also needed on a much more accessible basis.

An important conclusion to be drawn from this study is that the very low contraceptive prevalence that currently exists, and the dropout of method use that contributes to it, reflect supply constraints. The supply of birth spacing services of appropriate quality is simply insufficient. As the responses of these women show, interest in delaying, spacing, and reducing the overall number of pregnancies clearly

exists. However, this demand is unmet by current service provision. To increase prevalence and reduce dropout s, the supply of birth spacing services to meet the existing demand must be expanded. The solutions, therefore, must come from the providers of birth spacing services in both government employment and in private practice.

Based on the results of this study, the following recommendations are made:

**Recommendations**

***Recommendation #1*:** The MoH and its partners should develop a continuing education system give much greater attention to upgrading the skills of health center staff - particularly midwives - by strengthening counseling skills and technical knowledge about method options and management of side effects.

***Recommendation #2:*** A program of one-on-one facilitative supervision should be established at health centers and during outreach visits where resource persons observe birth spacing services and help providers improve their skills

***Recommendation #3:*** Health center staff need to provide birth spacing services to clients at times other than their standard morning operating hours, such as by assuring that at least one qualified service provider is at the health center for two or three hours each afternoon.

***Recommendation #4:*** Health centers need to conduct outreach visits to villages on a regular and predictable basis. These visits should include the full range of birth spacing services, e.g., promotion of birth spacing; counseling about method options; re-supply of pills, injections, and condoms; counseling for women experiencing problems; and promotion and counseling about longer-term and permanent methods.

***Recommendation #5*:** As part of skills upgrading and facilitative supervision, greater attention should be given to "life style" factors in counseling clients about method options, and management of side effects.

***Recommendation #6:*** Health center staff who conduct a private practice should be encouraged and assisted as part of skill upgrading activities to provide birth spacing services to their clients, including active promotion of birth spacing to increase prevalence and expand a potentially important part of their private practice.

# Annex A - Health Centers and Villages

**Health Centers Participating in the Birth Spacing Dropout Study:**

- Pourk
- Same Rong
- Kan Daik
- Mundol Muy
- Chriev

**Villages in the Health Centers' Catchment Areas**

| | | | | | |
|---|---|---|---|---|---|
| 1 | Ampil | 37 | Mundol Bay | 73 | Tropiang Sish |
| 2 | Ampil Peam | 38 | Mundol Muy | 74 | Tropaing Tim |
| 3 | Ang Krao | 39 | O | 75 | Tropaing Traing |
| 4 | Angrong | 40 | Phum Thmey | 76 | Varin |
| 5 | Bang Kong | 41 | Po Banteay Cheay | 77 | Veal |
| 6 | Banteay Chash | 42 | Po Cheay | 78 | Vihear Chin |
| 7 | Boeng | 43 | Pokraum | 79 | Wat Bo |
| 8 | Boeng Done Pa | 44 | Pourk | 80 | Wat Damnak |
| 9 | Bosh Kralanh | 45 | Prasat | 81 | Wat Po |
| 10 | Cheik | 46 | Preay Danherm | 82 | Wat Sway |
| 11 | Chong Kao Sou | 47 | Preay Kroch | 83 | Pem |
| 12 | Chreay | 48 | Preay Kuy | 84 | Kum Nou |
| 13 | Chreish | 49 | Preay Thlork | 85 | Kok Dong |
| 14 | Chriev | 50 | Proma | 86 | Rokar |
| 15 | Chrolong | 51 | Rokar Yea | 87 | Done Tror |
| 16 | Chun Lung | 52 | Roloursh | 88 | Ta Snei |
| 17 | Dam Daik | 53 | Sala Kamrerk | 89 | Trang |
| 18 | Dok Po | 54 | Salakansaing | 90 | Pro Yut |
| 19 | Kaksikam | 55 | Samrong Yea | 91 | Stung |
| 20 | Kampheim | 56 | Slor Kram | 92 | Kok Tlat |
| 21 | Khnar | 57 | Spean Chriev | 93 | Pourk Thmey |
| 22 | Khnar Chash | 58 | Spean Khaik | 94 | Kok Srok |
| 23 | Khnar Thmey | 59 | Stung Thmey | 95 | Kok Sromor |
| 24 | Khun Mok | 60 | Sway Cheik | 96 | Kok Thmey |
| 25 | Ko Kranh | 61 | Sway Dang Kum | 97 | Preay Veng |
| 26 | Kok Chan | 62 | Ta Cheit | 98 | Peam |
| 27 | Kok Chok | 63 | Tacheik | 99 | Chreashh |
| 28 | Kok Po | 64 | Tadeit | 100 | Chhouk |
| 29 | Kok Risey | 65 | Taphul | 101 | Bang Koang |
| 30 | Kok Tnaut | 66 | Tavien | 102 | Done Swa |
| 31 | Kro Sang | 67 | Teak Sin Khang | 103 | Ling Done Pa |
| 32 | Krom Bay | 68 | Tnaut | 104 | Toul Lveang |
| 33 | Krosaing | 69 | Traing | 105 | Prohoat |
| 34 | Krursh | 70 | Treak | 106 | Kok Choun |
| 35 | Loak | 71 | Tropaing | | |
| 36 | Loleay | 72 | Tropaing Run | | |