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Issue Paper on

Contraception

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COOPERATION AGENCY

Department for Democracy and
Social Development
Health Division

Sida's Health Division has during the period 1996–97 elaborated three policy documents.
These include;
– A Position Paper on Population, Development and Cooperation
– A Policy for The Health Sector
– A Strategy for Sexual and Reproductive Health and Rights

It was during this process that Sida commissioned a series of Swedish experts to formulate Issue Papers on specific areas as a basis for policy discussions. Considering that these papers are of interest to a wider audience the Health Division has now decided to publish some of them.

The views and interpretations expressed in this document are the authors, and do not necessarily reflect those of the Swedish International Development Cooperation Agency, Sida.

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Background

From family planning to fertility regulation

In 1968 the United Nations' Declaration of Human Rights in Teheran established fertility regulation as a basic human right, defined as the right for men and women to "decide freely and responsibly the number and spacing of their children." In addition, the UN Declaration of 1969 obliged governments to "provide individuals and couples with the knowledge and means necessary to enable them to exercise this right."

Since then, many countries have implemented national and/or donor-supported family planning programmes. The goal of most programmes, however, has been to reduce fertility and slow down population growth, rather than to secure the reproductive rights of the individual. Not until the International Conference on Population and Development (ICPD) in Cairo in 1994 (UN 1994) and the Beijing Conference on Women in 1995 (UN 1995), were family planning and abortion discussed in the broader context of reproductive health and rights (Sida 1995).

Definitions

The term "family planning" is mainly used for provision of (modern) contraceptives and "family" implies that contraception is restricted to married life. According to WHO (1994b) family planning is "to prevent unwanted pregnancies by contraceptive methods and the right to have children when wanted." Thus, contraceptive services and treatment of infertility are included in family planning services.

Fertility regulation is a broader concept, defined by WHO (1994b) as the process by which individuals and couples regulate their fertility. Methods that can be used for this purpose include:

- delaying childbearing
- breastfeeding
- use of contraception
- termination of unwanted pregnancies
- treatment of infertility

The concept of fertility regulation with abortion as one component met opposition in ICPD in Cairo and not until the term was changed to "regulation of fertility" was it included in the final document. In Beijing in 1995 this expression was used in a statement on reproductive health. Two of the components of reproductive health services are defined as follows:

1. the right of men and women "to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice", which according to WHO's definition of family planning, means contraceptive services (and treatment of infertility).

2. women's right to "other methods ... for regulation of fertility which are not against the law," which, according to the language from ICPD in Cairo, can be interpreted as the right to safe abortion care in countries where abortion is legal.

Fertility regulation and contraception

Regulation of fertility is practised in all societies. The need to decide on the number and timing of births is universal, as are the methods used since ancient times to do so, either by prevention or by termination of pregnancy. Historically, fertility decline has been achieved by means of cultural and social rules for marriage and family life, by traditional methods such as breastfeeding and withdrawal, and by induced abortion. The condom, men's technical contraceptive, has a long history, but not until recently have highly effective pharmacological contraceptives for women been available. In fact, the demographic transition in many countries in Europe, in Australia and in North America occurred long before oral contraceptives or other modern methods were heard of. Nevertheless, family planning programmes and fertility surveys of today focus on oral contraceptives, IUDs, and other modern methods, neglecting the widespread use of traditional contraceptive methods and induced abortion as birth control.

Patterns of contraceptive use

In recent decades contraceptive use has increased significantly in many parts of the world. Today over half of all couples in developing countries use a contraceptive-method, either non-technical, such as withdrawal or rhythm, or technical, including condom, the pill, IUD, male or female sterilisation (Population Action International 1997). However, contraceptive prevalence as well as method choice varies in regions and countries (Table 1).

In Europe and North America 72 percent of married couples practices contraception. Traditional methods, mainly withdrawal, are most common (22%) followed by oral contraceptive pill (16%) and condom (14%).

In Latin American countries, contraceptive prevalence is about 60 per cent. Two female methods, sterilisation (21%) and the pill (16%) are most frequent, while male methods are practised by just over ten per cent of married couples.

In Asia, like in Latin America, 42 per cent of eligible couples do not practise contraception. Female sterilisation is the main method (23% of married women) followed by another female method, IUD (16%).

In Africa, 82 per cent of all married couples are non-users. Among users, female methods dominate, especially oral contraceptives (6%) and IUD (4%). Condom for birthcontrol is chosen by one per cent, while male sterilisation is practically non existing.

Table 1. Contraceptive use and method choice by region, 1997

	non-use	*Percent of married using male methods:*			*female methods:*			
Region:		With-drawal	Con-dom	Male-sterili-sation	Oral-contra-ception	IUD	Female barriers	Female sterili-sation
Africa	82	4	1	0	6	4	2	1
Asia	42	5	3	6	4	16	1	23
Latin America	42	9	2	1	16	7	2	21
Europe, USA	28	22	14	4	16	6	2	8

Contraception in context

The context in which fertility regulation takes place includes the individual, the society and the health service. The choice of methods is dependent on the society, attitudes to family life and sexuality, legislation on population and fertility, the health policy, and the availability of reproductive health services.

Policies and practices

Many countries have an established population policy and laws and regulations on family life and reproduction. In some countries, family planning is promoted through national or local programmes, while others lack adequate supplies and services or have restrictions against contraception.

The influence of health professionals and religious or political leaders on people's choice of methods is reflected in the patterns of contraceptive use in different societies. While doctors in Japan and the former Soviet Union have long been very restrictive in recommending modern contraceptives, health workers in China and India aggressively promote contraceptive use and female sterilisation.

Contraceptive choices in the reproductive life-span

The choice of a particular method depends on the circumstances; on age, marital status, education, perception of body functions, personal preferences, and characteristics of the method. The importance of factors such as effectiveness, convenience, safety and costs varies between individuals and also for the same individual in different circumstances and periods of life (WHO 1993a).

Adolescents

The attitudes to sexuality in society or in the adolescent subculture are important for the decision to use contraception. In some cultures young women are not expected to be involved in sexual activities, while young men are excused for

their strong sexual needs. A girl who takes precautions by using contraceptives shows that she expects sex and is looked upon as promiscuous.

The actual situation influences the choice of method. Some young women choose the pill because they consider them easy to handle, while others find consistent use difficult to maintain. Since adolescents are sensitive to side effects such as weight gain or nausea, and anxious about potential negative long term effects of the pill, discontinuation is common. Since their sexual activity is also often of a more sporadic nature, more temporary means which are cheaper and easier to use are called for.

Condoms, which also offer protection against STD, would be a good choice for young people. However, high costs, embarrassment and lack of confidence are common obstacles in young men.

Spacing

In the childbearing years, various contraception methods are used for spacing. For six months after childbirth, or sometimes longer, a woman can rely on exclusive or predominant breastfeeding to prevent another pregnancy as long as lactational amenorrhoea lasts. After the return of menstruation, the choice of method depends on the intentions for the next pregnancy and the understanding between man and woman. For short term spacing withdrawal or barrier method are commonly practised. If oral contraceptives are chosen, progesterone-only pills (mini-pills) are preferable during the lactation period. For many years of spacing, the pill, IUD, or injectables would be appropriate.

After the childbearing years

People who have the number of children they want may consider using long-acting methods. If they definitely do not want any more children of their own, voluntary surgical sterilisation is an option for the man or the woman. For men, the condom is the alternative to vasectomy, while women have many options among reversible methods, including barrier methods, the pill, IUD, injectables or implants. In this period of life, couples have often tried fertility regulation methods before, and have their preferences. Non-technical or barrier methods such as withdrawal, safe periods or condoms carry fewer side effects than other methods, and would be a reasonable option for couples who have previously found them reliable.

Ethical aspects of contraceptive services

Currently, many family planning programmes are focused on regulation of women's fertility. Women are blamed for population growth and the aim of these programmes is to increase contraceptive prevalence among married women at fertile ages. Even male condoms are presented as a choice for women.

Ethical standards for the provision of contraceptive services have been formulated by women's advocates and health activists in collaboration with grassroots organisations (WEMOS/HAI 1992). These guidelines highlight the following issues:

- The need for a free and informed choice of methods
- The provision of balanced, objective information on fertility regulating methods

- Avoidance of incentives and disincentives which may influence the choice of fertility methods
- A health care infrastructure which enables the chosen method to be used safely.

Reproductive choice can be restricted either by the policies and aims of the programme or by lack of adequate services for or supply of the required methods. And above all by gender inequality. Freedom of choice is an illusion in societies where women are subordinated and their ability to challenge officials or husbands is extremely limited (Dixon-Müller 1993).

The potential risk for abuse or coercion varies between contraceptive methods and between the settings in which the methods are delivered. The more user-dependent a method is, the less is it possible to force the method on anyone. The more sophisticated the technique, the less probable is an unbiased, informed choice. The more long-term the effect, the less freedom to switch to another method. For permanent methods, the potential risk for abuse is high, especially when they are offered as the only option in aggressive family planning programmes.

Incentives and disincentives

In many family planning programmes, incentives and disincentives are used to promote contraceptive use in general and/or a specific method. Incentives can be either cash or material compensation to acceptors of a particular method or payment to service providers and to those who have recruited the clients.

In countries with strict population policy, such as China and Vietnam, social benefits including better housing, health care and educational opportunities are directed to small families, while those who give birth to more than the stipulated number of children have to pay fines in rice or money.

In India the government has long offered significant cash incentives to both acceptors and providers of male and, since the 1970s, mainly female sterilisation. Lately a new policy for targets and incentives in relation to sterilisation has been proclaimed. Compensation to health workers is to be removed from April 1996, while acceptors of female sterilisation still will get cash compensation and free medical care. This will not, however, guarantee women's free choice. Cash payment is a strong incentive for women who live under poor conditions and without the tradition or power to disobey authorities in society or the family. In addition, it will be hard to change target setting practices without sensitising and re-educating the public, decision-makers and health authorities, as well as health workers at all levels.

Quality of services

The elements of "quality of care," as defined by Judith Bruce (1990), include choice of methods, information given to the clients, the providers' technical competence, interaction between client and provider, the constellation of services, and mechanisms for follow-up and continuity. Confidentiality must be ensured and the client treated with respect.

A wide choice of contraceptive methods is often stressed as important. New methods, however, should not be introduced for the sake of broadening choice

unless adequate counselling, services and follow-up can be ensured. Even where few modern contraceptive methods are available, the choice of method can be expanded by adequate information on non-technical methods as withdrawal and periodical abstinence or barrier methods. Promotion of male methods will often broaden the choice of method and improve quality of care.

The attitudes and the performance of the service providers are central for the success of a reproductive health programme. Many health workers do a very good job but often lack support and appreciation. They are expected to produce remarkable results while working under poor conditions, usually poorly paid. Many have to supplement their meagre income from other sources. Instead of devoting time to counselling about several options, they choose to promote methods which are simple to apply or perhaps connected with provider incentives.

Training and retraining of service providers

Education and training are a necessary condition for good performance of health providers. Their basic training, followed by in-service training, should include both technical and communication skills. If a new technology or a new contraceptive method is introduced, health workers need skill-based training to manage their new tasks. To benefit from such training, staff must receive feedback, supervision and review of their performance.

Most important, but also hard to influence, are the attitudes of the health workers. Prejudice and rigidity are common, even among well-trained medical professionals. Therefore, the training should convey an understanding of the objective and means of the programme. Health workers should be allowed to take part in planning and management and be able to influence their own working conditions.

Description of contraceptive methods

No single contraceptive method is appropriate for all individuals at all ages or in all circumstances. Reliability and safety are important for acceptance and sustained use of a contraceptive method. The effectiveness of a method is determined not only by the characteristics of the method but also by the way it is applied and by factors beyond the user's control (WHO 1994a).

Fertility variation between individuals and couples is an important factor. Some highly fertile women experience repeated failures with methods such as IUD and barrier methods, while some couples are effectively protected by condoms and periodical abstinence. Failure due to incorrect or inconsistent use is common with methods such as contraceptive pills, condoms, spermicides and rhythm. IUDs can fail because of incorrect insertion or expulsion. In areas where diarrhoea is endemic, the absorption of contraceptive pills may be disturbed. Disruption of the supply of injectables and contraceptive pills decreases the use-effectiveness of these methods.

The following description is from Sundström (1994). For additional information, see WHO technical and managerial guidelines on various methods and MPA, 1994.

Traditional methods

Traditional or non-technical fertility regulation methods include withdrawal, rhythm, periodical abstinence, and the lactational amenorrhoea method (LAM). Since understanding and skills are needed to practise these methods, counselling on non-technical methods should be included in quality contraceptive services.

Withdrawal or coitus interruptus is a male method, practised since ancient times and still widely used in many societies. For instance, in Turkey and Poland 30 percent of married couples rely on withdrawal for birth control. The method can be practised without mechanical or pharmacological means. The requirements are male motivation and self-control.

A recent study has pointed out that health professionals often overlook withdrawal as a reliable contraceptive method (Rogow & Horowitz 1995). Instead of discouraging people from practising coitus interruptus, service providers should present it as a simple method without negative health effects. The message, especially to adolescents, should be that it is always better to practise withdrawal than to use no contraceptives at all.

Natural family planning, including rhythm, safe periods, and periodical abstinence, is an always available method for fertility regulation without any adverse side-effects. Recognition of the menstrual cycle and co-operation between man and woman are conditions for effective use of the method. A combination of natural family planning with other contraceptive methods should be encouraged (WHO 1988).

Breastfeeding or the Lactational Amenorrhoea Method (LAM) is introduced as a specific method for child spacing during lactation. This method is a reliable, safe, and readily available protection against pregnancy during the first 6 months postpartum, provided that there is amenorrea and full or nearly full breastfeeding. Promotion of breastfeeding, including information on lactational amenorrhoea as birth control, is an essential element of reproductive health care.

Barrier methods

In many industrialised countries, the condom has long been the most-used (or only) contraceptive, while few women use barrier methods. Today, ten per cent of contraceptives used world-wide are condoms and two per cent, vaginal barriers.

The condom is a simple, safe and effective method for fertility regulation. It is the only reversible contraceptive method for men. It is easy to handle and needs no additional means to be effective. The condom has no negative effects on health and offers protection against sexually transmitted diseases.

The diaphragm is a safe, effective and woman-controlled method. Historically it was introduced as women's own contraceptive and widely used in many western societies. Today it is propagated by feminists who reject hormonal or surgical means for birth control. Nevertheless, the resistance against its use is considerable in many societies and cultures.

Vaginal spermicides for women are offered for sale commercially and do not need any medical assistance to use. The effectiveness of the method is highly depend-

ent on motivation and correct use. The failure rate in practical use is many times higher than in controlled clinical trials. The need for re-supply makes the method expensive. Spermicides increase effectiveness of other barrier methods and can be used as a backup for other methods. They are also suitable during limited periods or when intercourse is sporadic (WHO 1987).

In conclusion, barrier methods provide effective birth control without any health hazards. They are easy to handle and allow the user to be in control. In addition, condoms offer protection against STDs (MPA 1994). Despite these advantages, barrier methods are seldom actively promoted in family planning programmes. For the sake of shared reproductive responsibilities and for health reasons, it should be a priority to reach men and promote the use of condoms as birth control.

Intrauterine devices (IUDs)

IUDs count for 19 percent of the world's contraceptive use. They are popular and widely used in some countries, but have very few users in others. The copper bearing device was introduced in the 1970s. A hormone-releasing IUD has been available from the late 1980s, still mainly used in developed countries. An IUD, inserted into the uterine cavity, offers long-term, effective contraception. The method is dependent on services for application, whereupon no measures are needed until the IUD is removed or replaced (MPA 1994). The return of fertility after removal is rapid and future fertility is not affected. The method is suitable during breastfeeding and the IUD can be inserted right after delivery or abortion.

The copper IUD, of which *TCu-380A* is recommended for high effectiveness and few side-effects (WHO 1990c), is currently the most prevalent type of IUD. The TCu-380A IUD is registered for up to ten years' use without re-supply. Increased menstrual bleeding is the most serious side-effect and the risk of genital infection in relation to insertion makes the method less suitable for nulliparous women.

Levonova is a combined hormonal and intrauterine contraceptive, releasing small doses of gestagen. The method gives five years' protection and is highly effective. Irregular bleeding and spotting are more frequent compared to copper IUDs but the total menstrual blood-loss is less than for other IUD-users or for non-users (MPA 1994).

Hormonal contraceptives

Oral hormonal contraceptives, contraceptive pills, are used all over the world today. When introduced in the 1960s, the pill was a breakthrough for highly effective, women-controlled contraception. Since then it has been widely used, extensively researched and intensively debated. Oral contraceptives are most popular in the North and in Latin America and less used in Asia and Africa. World-wide, 15 percent of all contraceptors rely on the pill. Orals are appreciated for being effective, convenient and not related to coitus, while fear of side-effects, dependence on regular intakes and re-supply are drawbacks (MPA 1994). Pills can be easily accessible at grass-root level by community-based distribution and services.

The combined Oral Contraceptive pill, COC, the predominant oral contraceptive, contains two synthetic hormones, oestrogen and gestagen. The pill effectively inhibits ovulation when taken daily in three week intervals with a break of one

week. In this week, a bleeding similar to the menstrual period occurs. The advantages are that the method is reversible and entirely controlled by the woman. It is highly effective when used correctly and consistently. Disadvantages include high cost and dependence on continuous supply. The pills may also be difficult to store or hide. Being a hormonal drug, it is not suitable for specific risk groups.

The progestagen Only Pill, POP, often called Mini-pill, contains only the gestagen steroid in low doses. The pills are to be taken continuously without any break. The Mini-pill can be a good alternative for women who experience or fear side effects of COC and for lactating women who want to use oral contraceptives.

In conclusion, the Pill is a popular and effective method, when provided to well motivated, well-informed women in a setting where inexpensive, sufficient and timely supply is available.

Injectable hormonal contraceptives are of two types. The dominating method is Progestagen Injectables, Depo Provera (DMPA) or Net-EN, containing only gestagen. In addition, injectables containing both oestrogen and gestagen (Cyclofem, Mesigyna) are available.

Injectables are long-acting, highly effective and dependent on regular administration every second or third month. The over all prevalence of injectables is one percent of contraceptive methods. Use is concentrated to a few countries in South and South East Asia, where DMPA and NET-EN have been provided in big family planning programmes (WHO 1990a).

The method is reliable and seen as convenient by many women. Side effects, irregular bleedings and amenorrhoea, are drawbacks in some cultures, while amenorrhoea can be advantageous in others. The slow return of menstruation and fertility after the effective period of the injections is a drawback.

The promotion of DMPA in developing countries before it was approved for contraception in most developed countries, including USA, caused controversy in the 1970s. Although Depo Provera was registered as a contraceptive method in Sweden, Sida in the early 1980s withdrew all development support to injectables because of reported misuse, coercion and lack of adequate information in large-scale projects. Since then, however, an increasing acceptance of injectables has been reported. In programmes, where Depo Provera is offered as one of many methods, it is a common choice. Many women trust injections and prefer this method to both pills and IUDs.

Against this background, has Sida reconsidered its policy on injectables. The potential risks for abuse should not lead to the method being abandoned, but to high standards of care in settings where the method is provided. Support should be approved to programmes which offer long-term injectables as an option among other reversible methods, and provide appropriate counselling, services and follow up.

Hormonal implants, Norplant, is a hormonal method, applied by inserting progestagen releasing implants under the skin of the woman's upper arm. The protective effect lasts up to five years. The method is used primarily in the North, mainly USA, and in a few developing countries, mainly Indonesia (WHO 1990b).

Surgical services are required initially and for removal, while no re-supply is needed in the five years the implant is effective. However, to be used safely, Nor-

plant needs high quality services for insertion, and continuous access to health services in case of side effects or demand for removal. Bleeding disorders are the main reason for discontinuation.

The method is not suitable for provision at community or health-centre level, or in countries or areas with a weak health infrastructure. Because of the risk of coercion, it should not be promoted in vertical family planning programmes aiming at population control.

Post-coital emergency contraception

Post-coital contraception (PCC) is a backup service to prevent a potential pregnancy after unprotected intercourse. There are two established methods of PCC to be practised when other contraceptives occasionally fail or are not used. The first is intake of combined hormonal pills within 72 hours of unprotected coitus. The other is insertion of an IUD within five days after intercourse. Both methods are reliable and easy to administer through primary reproductive health services. Information and counselling on PCC should be part of any contraceptive services. Users of oral contraceptives and barrier methods especially need information on PCC and where it can be obtained. A visit for provision of PCC is also an opportunity to provide information and services on other fertility regulation methods (MPA 1994).

Sterilisation

Sterilisation (Voluntary Surgical Contraception, VSC) is a permanent method for fertility regulation for men and women. In many developing countries VSC has been extensively promoted as the only option for family planning, while in others the method is hard to obtain for legal or religious reasons. Female sterilisation is the choice of 26 per cent of contraceptive users world-wide while male sterilisation is used by ten percent. In Africa, female VSC is not common and male sterilisation is extremely rare. In East Asia, female VSC is three times as common as sterilisation for men, and together they represent more than half of contraceptive use. In Latin America, female sterilisation, besides the pill, is the dominant contraceptive method, while hardly any male sterilisation exists.

Both male sterilisation by *vasectomy* (WHO 1986) and female sterilisation by *tubal ligation* (WHO 1992) are effective and safe options for couples and individuals who want effective and permanent contraception after the childbearing period. Vasectomy is easier and less expensive to perform, but tubectomy is also a rather simple surgical procedure.

When implemented in family planning programmes, the key problem is the question of persuasion and coercion, target-setting and incentives. Any sterilisation programme must meet high ethical standards to ensure integrity and freedom of choice. High quality counselling and services must be offered. The personnel must be adequately trained and receive reasonable salaries. To avoid bias in their recommendation of methods, provider-incentives should be abandoned.

Preferably, sterilisation should be integrated into general reproductive health services, together with a range of reversible methods for fertility regulation.

Contraceptive methods under development

Immunological contraceptives, in particular anti-hCG vaccine for women are under development and have caused opposition from women's groups and activists. Both the contraceptive principle, which interferes with women's immunological system, and the way research and clinical trials are carried out have been criticised. The ethical and technical aspects of the trials will be followed by a group of scientists and women's health advocates connected to WHO's special programme on Human Reproduction (WHO 1993b).

New contraceptives for men, including hormonal methods, new material for condoms, and occlusion of the sperm ducts are also being developed and tested in clinical trials. Some of these methodologies seem to be promising, but the overall usefulness of the methods can be estimated only on basis of acceptability studies in men from different cultures and ethnic groups.

New types of spermicides are extensively researched and tested to find effective prevention of unwanted pregnancy as well as protection against STDs.

Mifepristone, an antiprogestogen drug, has been tested for use orally as an emergency or once-a-month contraception.

Conclusions

Fertility regulation is part of sexual and reproductive health

Services for fertility regulation, including contraceptive services and safe abortion care are integrated elements of essential reproductive health care.

The overall objective for fertility regulation programmes is to promote women's reproductive health and to allow people to exercise their reproductive rights.

Specific objectives are:

- to prevent unwanted pregnancies by providing extended services for safe and effective contraceptive methods to men and women regardless of age and marital status, and
- to reduce maternal mortality and morbidity by provision of safe and legal abortion services.

Contraceptive services

Programmes for fertility regulation must be country-specific, planned and implemented after exploration of national policies, health care structures and needs of the people.

Any programme to prevent unwanted pregnancies should include:

- public education on sexuality, reproduction and gender issues
- training and continuous education of service providers
- easily accessible services on a wide range of contraceptive methods for men and women
- special activities to reach those at highest risk of resorting to unsafe abortion in case of an unwanted pregnancy
- post-abortion contraceptive counselling and services.

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