MICRO LEVEL ANALYSIS OF CONTRACEPTIVE DECISION MAKING: IN THE CITY OF AMSTERDAM

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By

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You are my God, and I will give thanks!! Psalm 119:28.

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1. INTRODUCTION

1.1 Background of the study

The development of this research topic is related to my educational background, work experience and future career. I did my second degree in demography. The title of the research thesis was "The effects of selected proximate determinants and socio-economic factors on fertility rates of rural women" (Negewo, 1994).

The basic information required for this study was obtained by interviewing 2063 women in reproductive age. Out of 2063 women in the reproductive age, only 106 have ever used reliable contraceptive methods such as pill, IUD and Injectable. At the time of the survey, contraceptive prevalence rate among married women was 4.6% The main reason for this very low rate of contraceptive prevalence was lack of availability of contraception for rural women.

The study indicated that factors like land holding, literacy program, income from livestock, marital disruption, infant-child mortality and spontaneous intrauterine mortality would associate with high fertility rates. On the other hand, formal education, contraceptive use, prolonged breast feeding and raised age at first marriage would have negative correlation with fertility.

Based on this finding, I suggested a population policy that strives to reduce fertility by concentrating its efforts simultaneously on increasing educational status of women,
improving health conditions and strengthening family planning program.

The unbalanced relationship between population growth and the carrying capacity of the land was the major issue. Breast feeding, periodic abstinence or bed separation, as it was called by the people, abortion using traditional herbs, written materials by priests and out migration were some of the measures taken by the people to overcome the problem. There was a rumour for infanticide also. From that time onwards, I decided to do researches in order to expand family planning programs to the most needy people.

The country (Ethiopia) launched a national population policy in 1993, a year before my graduation. After three months of my graduation, I changed my employment to the population office in Oromia regional state. Nevertheless, the fact that the national population office did not seem to give due attention to family planning and there are not many NGOs concerned with family planning has made it difficult to reach the majority of people at grass root level.

After two years of so much efforts in vain, I changed my employment to Family Guidance Association of Ethiopia (FGAE), a local non-governmental family planning association. Interesting enough, after one month, I received good news from Organon, a pharmaceutical company in Holland. They told me that I was the winner of Organon's 1996 international family planning scholarship. That put me on the track of my career again with confidence and hope.

Since then I worked for one year as a regional co-ordinator in an organisation (FGAE) that has been committed and pioneered to
family planning and reproductive health. In the regional clinic both medical and contraceptive services are provided. All types of contraception including various brands of oral pills, injectables of two and three months, all types of barrier methods, IUD, norplant and surgical sterilisation are given. Along with educational and counselling services, sexually transmitted (STD) and gynaecological examination and treatment are provided to rural, urban and adolescent population.

Although the achievement obtained in the project area was promising, there were a lot of defaulters. The main complaints of hormonal contraceptive were burning and headache. As the result of this, contraceptive users tended to listen unfounded rumours that circulated among themselves. They like to take milk to neutralise the effect of the hormones. This is attributed to lack of proper contraceptive information and knowledge.

This kind of users' perspective in developing countries, raised my inquiry to learn about influencing factors contraceptive decision making process in developed countries. Decisions involving contraceptive choice are of particular interest to me in light of my career. Looking into family planning decision making process of western culture would help me to eventually adapt to local circumstances.

1.2 Study site

Having this inquiry in my mind I tried to find a study place. Due to logistical reason the city of Amsterdam was chosen. Amsterdam is the national capital of The Netherlands. The national population is 15,300,000 while the city population is 1,100,000 (Amsterdam city guide, 1998). When I actually started to collect
the data, I found two serious problems in my way. The first problem was how to get volunteer respondents. An attempt was made to talk to people found on the street. The result was disappointing. Among those approached, some said that they don't have time. Others said that they are not interested in such research. The second problem was that the few respondents found were not open to disclose their intimate information on contraception and sexual life.

Contraceptive decision making involves human sexuality which is very difficult to unfold even in a place where sexual revolution has undergone. Because of these difficulties, I changed my approach. I decided to approach respondents in Amsterdam through personal knowledge and friends. That of course worked out very well. I could not find any other better way to do this research within this short period of time.

Knowledge about influencing factors associated with adoption of each method over time by users is very scant. It is an important research area to improve the provision of the services. Social and attitudinal investigations suggest that contraceptive use is a highly complex phenomenon influenced by many determinants (Condelli, 1986: 479-491).

1.3 Statement of the problem

In this era of population concern, every state has some forms of population policy incorporating family planning program. A country may adopt family planning program driven by mainly three policy oriented concerns.

The first concern is related to health. It is assumed that birth planning can prevent high risk pregnancies. As it is noted in the
literature, (Senanyake and Potts, 1995; UNFPA, 1997) the risk of maternal or infant morbidity and mortality is the highest in four groups. The four high risk groups are too young maternal age, (of less than 18 years); too old maternal age (of beyond 35 years); too many births (of more than four births); and too close pregnancies (of less than two years apart). In developed countries where maternal nutrition is not a problem and where good and regular antenatal, delivery and postnatal care are available, these risks may be somewhat reduced.

In a country like the Netherlands where contraceptive use and age at marriage is one of the highest in the world, exposure to high risk pregnancy is unlikely except in the case of child bearing after the age of 35 years. Because of priority given to career development through labour participation and education, several women in industrialised countries postponed child bearing to a late age. The Dutch government seemed to have had a subtle population policy that promotes two family size as a norm. That has already become the ideal family size for most Dutch people.

The second fundamental reason for adoption of family planning is human rights or reproductive rights concern. This is the premises of the current family planning situations in the Netherlands. Over the last quarter of a century, the ability of individuals to choose the number and spacing of their children has been recognised as a basic human right.

The third raison d'être is development rationale. The main argument behind this rationale is that uncontrolled population growth rate will have detrimental effect on national development. Where there is fast population growth rate, there cannot be national savings to expand socio-economic progress and prevent environmental degradation. This rationale was relevant to The Netherlands of 19th century when the country started to introduce
contraception mainly to control overpopulation. Presently in the Netherlands, however, population as an obstacle to development is not an issue. Rather, contraceptive services are considered as tools required for self-development. Theoretically, it is the right of individuals when and which and to what end to use the tools.

Based on these concerns, the Dutch government has made available a variety of contraceptive methods. Furthermore, various information dissemination mechanisms are in place to propagate family planning. The focuses given to one of these rationale, especially by media propaganda, may indirectly influence individuals' and couples' attitudes in making decisions regarding fertility and contraception.

There is a relationship between fertility and contraceptive decisions. Individuals' attitude towards their reproductive career can have influence on the type of contraceptive decision. For instance, when people are less serious about the risk of pregnancy in their fertility decision, they may opt for more safe and less effective method.

Thus one purpose of this study is to explore the relationship between fertility decision and contraceptive method selection in over time.

However, fertility decision is only one factor that may have an impact on the selection of contraceptive method. Contraceptive knowledge is another factor that may directly influence the decision process either positively or negatively.

There seems to be considerable evidence that contraception is
used almost universally by fertile couples in Netherlands. Most people do know about various contraceptive techniques and most do practice contraception in their either married or unmarried lives. Then it is essential to examine and understand factors influencing individual's or couple's contraceptive decision making process.

Any accepted contraceptive method has symbolic meaning that need to be unfolded. With respect to contraceptive technologies, it is evident that most researchers are involved in assessing what kind of a contraceptive methods women use rather than trying to understand why they use it and what they think about it. This is another focus of this study.

In some developing countries, contraceptive decision making demonstrates non-egalitarian patterns. Rudolph (1974:179) writes that in rural areas of Iran where patriarchal authority exists male decides on most of the issues within the family. But in industrialised countries egalitarian patterns of the decision process may prevail. In most cases, contraceptive decision making process is a joint decision involving couples, family members, friends and medical doctors in one way or the other forms. Several authors (Fishbein, 1972; Jaccard, 1981; Townes et al, 1977; Wernner & Middlestadt,1979) described this aspect of others' influence on individuals contraceptive choice as influence of 'normative beliefs'. This is also an area of interest in this study.

Sciortino and Hardon (1994) review the studies on fertility regulation in The Netherlands. In the review report, they indicate lack of qualitative data on men's experiences with reproductive technologies: "How men behave and think in regard to contraception and whether men contribute to women's decision to use a certain contraceptive are questions which remain
To this regard, I will explore the nature of others' influence and the reasons for conformity with others' perception. I will especially give more emphasis to male partners' responsibility for and participation in contraceptive decision making process.

In short, the purpose of this study is to find out the underlying assumptions and cognitive reasoning of individuals in contraceptive decision making. Decision making is a process whereby various alternatives are considered in order to choose the best among available options. Whether the decisions are rational or not depends on subjective judgements. I may not indulge myself into the evaluation of the rationality of the decisions. Rather, my focus is on factors influencing contraceptive decision making at a certain age and historical time of individual's reproductive career. This includes as explained by Nichter and Nichter (1996) consideration of how alternative family planning methods are assessed and at what point various methods are adopted in a woman's or man's reproductive career. Qualitative researches that discuss factors influencing contraceptive decision making process as outlined above are rarely available in Netherlands. This research will attempt to fill this gap.

1.4 Objectives of the study

The general objective of this study is to identify factors that influence contraceptive decision making process.

The specific objectives include:

(A) to identify which background variables have impact on
contraceptive decision making process

(B) To understand individual's perspective regarding contraceptive decision making process

(C) To examine the impact of social and contextual pressures on contraceptive decision making process

(D) To identify linkages between fertility decision and contraceptive decision making process

1.5 Limitation of the study

There are many factors that limit the completeness of this study. The size of the respondents and the method of selection are major limitations. In no way can this study claim to represent the views of contraceptive method users in Amsterdam. The perceptions and personal experiences of the respondents as well as the researcher can also influence the result of this study. However, all possible efforts have made to minimise this risk.

1.6 Organisation of the study

Including the introductory chapter, this paper is organised into five chapters. Chapter two presents review of literature where studies conducted on the subject are reviewed. Chapter three discusses the methodology of the study including the type of the study, method of data collection and analysis. Chapter four presents factors influencing contraceptive decision making process. Finally, chapter five presents a summary of the major findings of the research and conclusion.
2. LITERATURE REVIEW

2.1 Public debate on reproduction and contraception

It almost seems that the Netherlands population size has been a point of focus in the minds of every Dutch citizen over the ages. The basis of this concern has been high population density compared to the total area of the country.

In comparison to other European countries (such as France), until the turn of 20th century, the Dutch birth rate did not show a declining trend. Uncontrolled population growth was seen as the cause of many evils (poverty, famine, crime, disease) and as a menace to the society’s peace and stability (Sciortino & Hardon, 1994:11-15).

From such kind of vision (basically, a Malthusian vision), a famous prolonged public debate emerged. The main theme of the public debate was human reproduction control. It was then determined that population growth had to be controlled.

Nonetheless, no synthetic contraceptive method was available at that time. The cervical cap was invented in the early nineteenth century and caps were on sale in New York in the 1860s, but it was not in The Netherlands. It was in 1882, Aletta Jacob (1854-1929) the Netherlands’ first female physician, started providing contraceptive service using diaphragm (pessaruim, it is also known as the Dutch cap).

With the introduction of the new method, the public debate took
new dimension. Discussions were carried out on the right to sexual pleasure for its own sake and its consequences on the moral fabric of the society. In light of this, Johannes Rutegrs (1850-1924), a clergyman and physician had played a central role in the propagation of the idea of contraception and contraceptive services.

Because of the public debates and introduction of the new method along with the personal contribution of the two prominent individuals, The Netherlands population growth started to decline at the beginning of 20th century. Consequently, the link between contraception and population control gradually vanished. However, the discussion concerning fertility control in relation to sexuality had not ended until the late 1960s.

Until mid 1960s family planning was a taboo for most Dutch people. The Catholic religion had strong influence during those days. However, as noted by Ketting (1995) after 1965 the population problem was primarily defined in terms of lack of space, and later also in terms of pressure on environment and individual well-being for which industrialisation cannot be a solution. This notion has changed drastically the population debate in favour of family planning. In addition to the obvious population problems mentioned above, the introduction of a reliable contraceptive pill in 1963 has brought further attitudinal changes among moral and religious leaders and public as well.

The development of the contraceptive pill was a great breakthrough. There were several pros and cons concerning pill from different categories of the society at the time of its introduction. Women and media accepted the method and tried to convince the medical professionals to prescribe it as a means of contraception. Pill was a reliable method. It was also an easy
method to administer. The method has also contributed to the liberation of women. It has enabled the women to explore their own sexuality without the fear of getting pregnant. The feminist groups and women accepted the method enthusiastically while the conservative groups especially the Catholic religion followers disapproved the use of pill (Levie, L.H.1990).

At that historic time, although there was a feeling that the country was over populated compared to its total land size, contraceptive use was not encouraged as a solution to the problem. Rather emigration was encouraged. The implication was that the population problem was defined not only in terms of space but also in terms of employment opportunity.

This situation has led to a huge change in the population's attitude toward sexuality and fertility during the period 1965-1975. The conflicting views concerning pill contraception were exhausted. In that, different social categories showed a great uniformity in fertility behaviour at that time. This uniformity can be explained by the emergence of both common norms approving contraception as a means of self-reliance for women and the ideal of the two-child family. Contraception, especially the pill, has become widely accepted among all social strata and religion no longer accounted for differences in the use of pill.

Heeren (1978) studied the development of opinions concerning family size in The Netherlands. He concluded that the different social groups have developed a great uniformity in fertility behaviour owing to common norms and values of a two-child family.

Nonetheless, the rapid acceptance of family planning can largely be attributed to non-governmental organisations that were the
forerunners of the family planning movements including The Dutch Association for Sexual Reform (NVSH), motivated general practitioners, active media involvement and public insurance (Ketting: 1995). As the result of this the Netherlands has achieved the highest contraceptive prevalence rate in Europe (70% for women in reproductive age). In 1988, 70 percent of all women between the ages of 18 and 37 used contraceptives (Delft, M.van & Ketting, E. 1992).

Since 1977, further change was introduced in the arena of public debate on reproduction. Instead of socio-economic and environmental consequences of population, individual well-being was now strongly emphasised (Ketting: 1995).

Although, initially welcomed as technologies that benefited women's emancipation, certain contraceptive methods were suspected for having adverse side effects on women's health. Consequently, hormonal contraceptives and intrauterine device (IUD) have been criticised by feminist health advocators. Further, it was argued that contraceptive methods created a situation where women's body was subjected to biomedical science.

The family planning that has contributed for women's liberation, has become under critique by feminist health advocators in seventies and eighties. The feminist health groups advocate for barrier contraceptive methods which don't have major side effects compared to hormonal contraceptives (Hardon: 1992).

The adoption and practice of family planning has developed without explicit government interventions and policy guidelines (Ketting: 1995; Schaafsma and Hardon: 1997). The position of the government was to follow the general consensus of the population. However, the government of Netherlands has always supported
family planning, not from the economic, social and environmental point of view but to enhance individual well-being or to improve the health status of the population. The motive behind this trend is that the Dutch government has adopted family planning as human rights or reproductive rights. The public debates on population growth and contraception provide contextual influence for contraceptive decision making.

2.2 Quality of Care

The quality of service has a striking impact on the reproductive health and contraceptive choices. The challenge for reproductive health programmes is to provide access or services to clients with the highest feasible levels of quality. The Rutger Stichting in Amsterdam is providing medical services and family planning programmes as an integrated components (see doctor's perspective in this paper).

In Holland, the quality of family planning, measured by the declining percentage of unwanted pregnancies, has increased during the last decade. This success can be attributed to the continuos efforts of the government, the press, schools and professional care institutions with respect to fertility regulation. The use of contraceptives is widely accepted since the 1960s. (Delft, M. van & Ketting, E. 1992).

However, studies done by Schaafsma and Hardon (1994) on the situation of family planning in Netherlands from providers' and users' perspective have revealed that certain methods are not easily available, specially barrier methods are given less attention. The costs of certain contraceptive methods are not reimbursed. Thus, it is hardly possible to generalise that all contraceptive methods are easily accessible and affordable in the
Netherlands. This situation, to some extent, can limit the clients' choice of contraceptive methods (see also doctor's perspectives).

Sciortino and Hardon (1994) review most of the available research on fertility regulation in the Netherlands. They indicate not only research gaps in the field of family planning and reproductive health but also their doubt on the plausibility of free choice of contraceptive methods for all Dutch citizens. Furthermore, a little is known about individuals' or couples' contraceptive decision. Why these individuals or couples favourably adopt one method of contraception over the other? What are some of the important factors that influence contraceptive perceptions and attitudes?

2.3 Contraceptive decision

Beckman (1987:61) defines fertility decision as a sequential process in which couples decide whether to have another child or not, rather than how many children to have. According to Beckman's fertility decision model, both wife and husband make a joint decision regarding whether to have a child or not. According to this model, the strength of couples' fertility intention determines the strength of joint decision. The fertility intention is influenced by personality characteristics, socio-demographic characteristics, motivational influences and economic factors of the couples. In this sense, the joint decision of fertility will have direct influence on contraceptive choice and use.

Condelli (1986) has examined factors associated with choice of contraceptive methods such as pill and diaphragm using the health belief model. Convenience, concern about side effects and
protection from pregnancy were among the most important variables related to choice. For most contraceptive users, pill was the most convenient method. The health belief model suggests that women who perceive themselves at greater risk of an unintended pregnancy are more likely to use effective methods of contraception. Consistent with this prediction, pill users reported feeling more susceptible to pregnancy from unprotected intercourse than did diaphragm users. Further, pill users felt more protected from pregnancy when using the pill than did the diaphragm users. Pill users engage in more frequent intercourse and thus feel they need to use a more effective method. Therefore, perception of susceptibility to pregnancy appears to be one of the most important variables in influencing choice. According to Candelli's finding, perceived susceptibility to pregnancy and involvement in a sexual relationship were associated with choosing the more effective method of contraception, the pill.

Of further interest is the role of subjective norm, which appears to be powerful influence on contraceptive decision making. A systematic evaluation of these and other variables will assist in promoting better contraceptive practices.

Olton studies (1994) on Antillian women in Amsterdam shows that women with middle or high level of education and labour participation have a low fertility level. According to Olton, it is not these factors, however, that lowered their level of fertility but rather their high ambition and strong urge for social mobility. Of course, to achieve career advancement and high socio-economic status, the postponement of fertility to latter time is inevitable in rapidly changing world. To do so women must decide to use a contraceptive method if they are sexually active and fertile. In this sense, career advancement determine fertility decision and then contraceptive decision.
More specifically, the latter requires to acquire information on the type of contraception available, their efficacy, side effects and price.

Moors, H.G. (1974) has conducted a socio-demographic study of fertility behaviour based on cohort research. The result of the study indicated that achieved characteristics such as religiousness, labour force participation of the women, and housing situation seemed to gain significant importance as predictive factors affecting fertility. With regard to religion, it was stated that in the 1968 cohort, the difference in attitude between Reformed and Catholic women had disappeared.

Knowledge about contraception and conception are also important in influencing methods choice. Contraceptive practices are directly affected by contraceptive knowledge (including beliefs about susceptibility to conception, perceived consequences and beliefs in others' perception). Jaccard et al (1996) identify four aspects of contraceptive behaviour of individuals:

First, the individual must decide whether to use contraception in general and, if so, she or he must decide what method to use. A second aspect of contraceptive behaviour is the consistency of contraceptive use. Consistency refers to the proportion of times that an individual uses contraception over a specified time period. A third aspect refers to accuracy—to what extent the method is used correctly. A fourth aspect of contraceptive behaviour focuses on continuity.

At any point in time, individuals will have the most preferred method of contraception, which she or he will identify as her or his major method. What factors helped to identify the method?
This is an important research question to investigate. However, over time, individuals may change their major method of contraception. Of interest is the identification of factors that lead to changes. As indicated by Jaccard, assessing both individual and contextual situations are important for the fact that contraceptive use depends on the attitudes of individuals, couples, family members and family planning service providers. It also depends on the type of contraceptive technology available. As indicated in the on going discussion, contraceptive decision is a process that allows others' involvement. The one with adequate knowledge and up-to-date information may have the decision power. One can obtain knowledge from various sources like books, mass media, individuals, community, and health or family planning institutions.

Werner and Middlestat (1979) studied factors that influence the use of oral contraceptive by young women. The results of their study indicated that individual's attitude towards contraceptive consequences and influences of others are important in predicting pill use.

For decision making to take place, certain preconditions are necessary. A person must have a choice. One may need to think seriously before making decision, because some contraceptive methods are not reversible. A person must be assisted to decide freely and responsibly.

Contraceptive practices are directly affected by decision process and perceived accessibility, availability, and affordability of various contraceptive methods. But appropriate contraceptive knowledge or information must be a tool for free and responsible decision.
2.4 Research questions

(A) What are the linkages between fertility decision and contraceptive decision?

(B) What are the expressed reasons for using contraceptive methods?

(C) What are the specific and general attitudes that influence contraceptive decisions?

(D) What are the attitudes of male partners towards contraceptive use?

(E) What process do contraceptive users go through in choosing methods?

3. METHODOLOGY

3.1 Type of study

The detailed understanding of the influencing factors associated with adoption of each contraceptive method over time by users is an important research area to be explored and described. Therefore, the type of the study is exploratory and descriptive nature.

3.2 Study design and data collection

The study is qualitative in design. Open ended semi-structured questions were used as the main tool to collect the information required for this study. 23 individuals were interviewed. Out of the total 23 respondents, 14 and 9 were women and men respondents.
respectively.

4. FACTORS INFLUENCING CONTRACEPTIVE DECISION MAKING PROCESS

4.1 Background characteristics of the respondents

Fishbein (1972:222) has noted that, demographic variables (such as education, residence, and religion), personality variables (such as dominance, anxiety, authoritarianism) and other psychological and social-psychological variables (such as love of children, self-image, various general attitudes, e.g., toward contraceptives, overpopulation, and various general intentions, e.g., to have a career, to marry late) can influence family planning intentions, and thus behaviours, only indirectly. These are external variables that have influence on behavioural intentions.

Other non-individual background variables such as mass media propaganda and established norms of the society have also influences on individual's intention to favour or not to favour a contraceptive method.

In this study, data on individual characteristics including age at marriage, religion, education, marital status, age at first child and career development were collected to examine their indirect influence on contraceptive decision making process. According to this perspective, the background variables are thought to function by directly influencing individual's perception and power with regard to contraceptive decision
making.

In the present study, religion and education don't seem to have significant impact on the variation of contraceptive decision making process. Nearly, all the respondents are not religious. Religion, does not seem to have impression on the individual's day to day activities. It is not part of the thought as such, at least, among these study groups. Hence, I tend to conclude that religion does not account, as it does in most developing countries, for the variation in contraceptive decision making process.

Another background variable is the level of education acquired by the respondents. This variable is also known to have strong correlation with contraceptive use in developing countries. In this study, nearly all respondents have similar level of education. Most of them have reached university level. But they acquire quite substantial knowledge about contraception and reproductive system in biology lesson at high school level. Besides this, there are a lot of reading materials on contraception and reproductive system produced by various agents like women activists, family planning and reproductive health pioneers. So that everybody has information about the pros and cons of contraceptive methods. Therefore, there is no significant variation in contraceptive decision making based on the level of education.

Given the nature of partners relationship in this society, analysis of age at marriage and marital status is difficult for this study. Rather, stable and unstable relationships are better concepts to examine linkages between these variables and contraceptive decision making process.
Out of the total respondents, 12 respondents have had a stable relation with their partners for a long period of time. They have been like husband and wife. 10 of them have had one to four children. The other two have already stopped using contraception to have the first child. These people have more knowledge and experience about contraceptive methods than who have unstable relation with their partners (11 respondents). They have tried a variety of contraceptive methods including both reliable and unreliable methods such as abstinence, condom, coitus interrupts, rhythm, sponge, pill, IUD, Diaphragm, male and female sterilisation.

The use of unreliable method among most partners with stable relationship indicates that they have been reluctant in prevention of pregnancy in spite of the possibility of frequent intercourse. Most of them used less reliable methods during their initial stage of sexual relationship and between pregnancies for child spacing. These two situations are different though people used similar contraception. The former situation may indicate lack of experience while the latter may mean, with stable relationship, there can be haphazard fertility decision that may lead to less reliable contraceptive choice. For instance, seven respondents who have children used condom between pregnancies as child spacing method. Some of the partners in this group might have unmet desire for more children. Those who have accomplished their desired number of children have used reliable methods.

The other 11 respondents are categorised as people who have unstable relationship with their partners. They have used a very limited number of contraception such as periodic abstinence, condom and pill, most of the time by combining the last two. This implies that when the relationship is not stable, both partners are more cautious about unexpected pregnancy. This explains why they use more reliable method than people with stable partners.
This study reveals that the type of relationship (stable or casual) is more important than the frequency of intercourse in determining contraceptive choice. With a casual relationship partners tend to adopt reliable methods. Striking enough, most adolescent people (young girls and boys), are more serious about both pregnancy and sexually transmitted disease than people in their age in the past. Some of the adult partners started sexual intercourse without protection or using traditional method such as coitus interruptus. Contrary to this experience, two young girls who have started sexual intercourse while taking contraceptive pill, without combining condom, have immediately tested for HIV/AIDS.

This study reveals that age at first child and career development have strong impacts on contraceptive decision making process. Out of 14 female respondents, 6 of them have a total of 18 children. At the present stage of their life and time, most of them are satisfied with number of children they have. For this group, the mean age at first child is 27 years. Interestingly, the ideal mean age for the first child among the female respondents with no child (8 respondents) is 28 years. The ideal mean age at first child is one year more than the actual mean age at first child. Most of the respondents don't want to have children after 35 years of age. Those who are after 35 years of age (5 respondents), use a very reliable method like pill or sterilisation to prevent unexpected pregnancy.

All respondents were asked about their expressed reasons for present use of contraception. Various and over lapping answers were given to this question. Some of these answers were: to regulate menstrual disorder, to have the pleasure of sex, to prevent pregnancy and sexually transmitted disease. Further question was asked why they prevent pregnancy. For half of the respondents child raising, at this moment, does not fit into

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their program. Being curious about this answer, one wants to know why their program cannot be compatible with parenthood. The findings of this study suggest that they want to finish their study, get good job, and find stable partner before beginning their reproductive career. The other respondents, have two main reasons for preventing pregnancy: They are too old to have another child or they don't have enough room to add another child. The latter reason was striking. Because I have never heard before, couples giving insufficient room as a reason for not to add more child.

4.2 Contraceptive knowledge

The following questions were asked to evaluate the contraceptive knowledge of the respondents: name of contraceptives methods they know; their perspectives on how the methods prevent pregnancy; and what the side effects and contra-indications of contraception are.

As to the awareness of the contraceptive methods, nearly all respondents know the name of most methods. The names frequently mentioned include pill, condom, IUD, diaphragm and surgical sterilisation. A few respondents mentioned by themselves other contraceptive methods such as Injectable, implant, persona, female condom. The barrier methods like cervical cap, foam tablets, sponge are seldom mentioned.

The responses to the second question was limited to two established contraceptive methods, namely, pill and IUD. The range of responses to this question vary from no clue to biological explanations. Most of the young respondents tried to remember their biology lesson to explain how a particular method works. That was not easy. Most of them have forgotten the
biological explanation due to time gap. They eventually bring out their perspectives from the back of their mind.

According to this perspective, the pill prevents pregnancy by changing the normal functioning system of natural hormones in the body. Others perceive that pill prevents pregnancy by simply suppressing ovulation. When they are asked how it suppresses ovulation, they come to say that it changes the normal functioning system of the natural body mechanism. Others say that they have forgotten what they have read and learned. A few say that they don't have a clue how it prevents pregnancy.

Some people have expressed that they are scared of contraceptive pill because of its systematic effects on the reproductive tract and on menstrual cycle. Some of the respondents feel that the way pill controls menstrual period is too unnatural.

With regard to IUD, some respondents consider it as a mechanical object inserted into the uterus. According to the explanation, it prevents pregnancy by occupying most of the space in the womb which would otherwise be used by fertilised embryo. Others believe that it prevents pregnancy by aborting early conceived conception. According to this perspective, when the fertilised eggs reach from fallopian tube to the uterus, the womb vibrates to expel the conception. One partner said that the IUD prevents pregnancy because the copper lead will dissolve and gradually leak into the blood system.

Dr. Hannie's (see Dr Hannie’s interview in appendix) comment on this point is partially agreeable with the respondents' perception about IUD:
It probably does leak into the bloodstream as some coppers completely disappear after many years when checked out. The disappeared copper might have been taken into the bloodstream. As far as I know this does not have an effect on the health of the women and their foetus as well. However, in some women after ten years of staying in place nothing happens to the copper. It is just new. How does IUD prevent pregnancy? The copper will make the sperms immobile so that fertilisation cannot take place. But you cannot deny that sometimes fertilisation can take place and the second action of the copper is to prevent implantation of the fertilised embryo. Some people consider this as a form of abortion. It depends on what someone considers pregnancy. For some people pregnancy begins after implantation. So they will not consider copper as abortion method. For some religious women who opposes abortion, it would be a difficult method. I cannot disprove with these group of women that there is no abortion. With other type of copper that contains hormone, I can assure that pregnancy cannot take place because it works by thickening the wall of the uterus too much so that the sperm cannot pass through uterus.

As to the side effects and contra-indications, most respondents view hormonal contraceptives as potentially dangerous to their health. The possible side effects indicated include cancer, heart failure, blood clotting, liver problem etc. Most respondents associate IUD with infection and sterility.

Some of the contra-indications of pill mentioned by respondents include smoking and some illness like heart failure and hepatitis. The sources of their knowledge are school lessons, books, various reading materials and friends.

Two respondents, though know the undesirable adverse effects of
pill, would like to mention the beneficial side of contraceptive pill only.

Knowledge about contraceptive methods specifically that of oral contraceptive method is substantial. Most users know different brands of pill with low content of hormone.

Most of the contraceptive users have explained that, the family doctors did not tell them about how the methods work (their actions), their beneficial and adverse effects, indications and contra-indications and other aspects of their use.

In line with respondents' perspective, Dr Hannie pointed out to what extent people are given reliable and meaningful information concerning how the contraceptive methods work, their health side effects and contra-indications:

As I said family doctors are not good enough to tell about alternative methods of contraception, let alone how methods work, their side effects and contra-indications. Providing reliable and meaningful information is important for a patient's compliance with a method. It will help to increase continuation rate of contraception. In Holland contraceptive discontinuation is not as such a problem compared to other countries. Here women prefer to take the risk of contraception rather than becoming pregnant. That is why age at child bearing and contraceptive continuation rate are very high though contraceptive options and choices are not pleasant that much. The available information is highly biased towards pill.

Are there any contraceptive rumours that spread among the people.
which don't have scientific ground? Dr Hannie's reply to this question is precise and clear:

Yes, there are many myths especially about IUD. Many people say that IUD is not reliable and it causes infection and as well as infertility. There are also some rumours about pill, for instance, some people think that certain brands of pill can cause cancer. All these rumours can influence contraceptive choice.

4.3 Contraceptive perception and attitude

People's attitude towards contraception is partly based on their perception of how the regime works. They tend to give more opinions about the methods they have been using. They favour methods that fit them. Those who have been using oral pill for clinical reasons favour the pill. They tend to cancel the negative consequences by the positive consequences of the pill. Most people tend to have negative attitude for methods they have never used than for the methods they are currently using.

There is one general agreement among nearly all users of pill. They regard the oral contraceptive pill as a chemical and artificially synthesised hormone which may complicate with the normal functioning of natural hormones in the body. They feel that taking of the hormone into their body over long period of time would have effect on the health. They assume that the longer they take the hormone into their body the more the effect would be.

In spite of the negative attitude from the people, pill is the most widely used contraceptive method in The Netherlands (34%).
Out of 14 female respondents, in this study, only 2 of them have not tried pill so far. According to Senanayake and Potts (1995), the factors which determine pill use include biological factors such as family size and age; effect of media; religion; medical, legal and political aspects of the family program in the country; and the availability of outlets where the pill can be obtained.

Some of the side effects encountered by the users of this method include weight gain, headache, depression, amenorrhea.

Some of the advantages mentioned by the respondents were: easy to get (it only needs the prescription of the doctor), easy to reverse (just quit its use), increase sex freedom (no fear of pregnancy), included in health insurance (it is subsidised by the government), has side benefits (treatment for irregular menstruation and other benefits), reliable method, reduce dependency on medical professions, does not involve body manipulation, provides power to women to control their fertility.

The second most favoured method is condom. Nearly all respondents have tried condom for either to prevent pregnancy or sexually transmitted disease. Most of the time they used it in combination with pill. For most of the respondents condom is not a reliable method for fertility control. They told me that certain brands of condom contain spermicide which they call The Dutch double. But none of them have tried that kind of condom. The main purpose of using condom is to prevent sexually transmitted disease. Some users complain about the price of condom.

Condom has both advantages and disadvantages. Some of the contraceptive and none contraceptive advantages or benefits of condom indicated by the users include safe, allow male involvement in contraceptive decision making and practice, can be
obtained easily, provides sexual freedom, prevents sexually transmitted disease and pregnancy though less effective, reduce mechanical friction and irritation of the penis or vagina, enhance sexual pleasure, and used to reduce premature ejaculation. A good number of people seem to use condom to prevent sexually transmitted disease and unexpected pregnancy.

Some of the disadvantages of condom mentioned by respondents include interruption of sexual intercourse after erection has occurred while placing the condom on the penis, unacceptable to some men and women because of the lack of genital contact, reduction of or perceived to reduce a man’s or woman’s enjoyment of intercourse, irritation caused by allergic situations to the spermicide added to some condoms or the plastic rubber, easily broken or torn by finger-nail or other sharp objects which render them useless or slip off during intercourse and expensive for certain people. The first and the last points are frequently expressed by most respondents.

Some respondents have the propensity to suggest that the price of condom be included in the health system which they think can increase the number of current users even more.

Nearly all respondents regard pessarium (diaphragm) as an awkward method for practical use. One male respondent whose partner was using the method commented that it is a disgusting thing to carry that big box of pessarium.

IUD is most favourably appreciated by those who have some problem with pill. One of the respondent who is now 49 and became menopause at the age of 45, resented very much for not using spiraaltje (IUD) from the beginning of her contraceptive career. She switched to spiraaltje after several years of suffering from
the side effects of pill. Why did not she switch to spiraaltje as early as possible? She responded that pill was a popular method during those days than any other methods. The same thing happened to other people in her age group. Still many people don't like the contraceptive method spiraaltje. They associate this method with infection and sterility. A few respondents dislike the dependency of the method on doctors for insertion and removal. They dislike not only the dependency but also the body manipulation.

Five, have practically used IUD to prevent pregnancy. Among these, one respondent had become pregnant while the method was there. She kept the method for ten years. It is common knowledge that its effectiveness decreases after ten years. Probably she had used it for more than ten years. One woman developed infection and another woman had heavy bleeding.

The actual side effects encountered by few respondents who have used this method include pain, increased bleeding, infection and contraceptive failure. An IUD gives long-term, easily reversible, coitus independent contraceptive protection; it does not require continuous motivation for effective use.

A few elderly men tend to favour the traditional method known as leaving the church before singing than condom. This method is also called coitus interrupts or withdrawal. For most of the respondents (especially for adolescents) this is a risky method to prevent pregnancy.

The norplant, female condom, cervical cap, suppository, foam, jelly and creams are negatively favoured. The basis of this attitude is that most of the respondents don't to consider the method reliable for birth control. Contraceptive effectiveness
is extremely important for young girls with urgent career development.

In order to get some insights about the contraceptive choice, it is essential to examine the perceptions and attitudes of couples:

Ms Care (37) and Mr Steve (39) are partners. They have two children. There are four years differences between the two children. Ms Care's desired number of children is 3-4 while that of Steve is 6.

First that of Ms Care:

I don't like the way people plan children. It seems to me that as if everything has to be planned. Sometimes people easily frustrate when their plan fails. For instance, I born my second child a little bit later than my expectation. I don't like pill as a contraceptive method. Because I don't want the synthesised hormone in my body. I knows all types of contraceptive methods. But I have never used any of them except condom. I believe that there is no clear cut information about the side effects of contraception (especially the hormonal and the intrauterine device or IUD). So that to be on the safest side, I have been refrained from using contraception that may affect my health. My partner wants one more child. But I refused to accept him at least for the moment. We don't have enough rooms to add more child.

Mr Steve's comment:

For me hormonal contraceptives and IUD are intrusive. They
are necessary things as well as dangerous. But they are more
dangerous for the health of women than the risk of
pregnancy. Copper is poison. It is put in a delicate place
that enables it to leak into the blood stream. Pill changes
the natural hormone system in the body. Partly, this is how
these two methods prevent pregnancy.

Both couples agreed to use condom as a contraceptive method. They
believe it is a safe method for health. But they also know that
it is less reliable method for pregnancy prevention. It seems
that accepting the cost of pregnancy is better than the cost of
health at this moment. But it is most likely that this joint
decision, might change after a few years primarily because of two
possible reasons. Either they will add one more child and satisfy
their desire for children or they may fear the risk of pregnancy
at latter age and decide to prevent pregnancy. When one of this
conditions is fulfilled, most likely, they might switch to a more
reliable or permanent method. Hence contraceptive decision is a
complex process whereby multiple biological and psycho-social
factors are interwoven to influence the perception and attitude
of couples.

In this specific case, for instance, the unmet desire for one
more child and the fear of contraceptive side effects forced the
two couples to accept more safe and less effective contraceptive
method. That is condom. Their age also matters. As time goes on,
other factors may come into considerations as dominant
influencing factors. The Ms Care told me that if condom fails and
pregnancy takes place, she will not go for abortion. That is why
perhaps she disliked strict planning of children. This kind of
perception and attitude appear to fit her present interest
regarding procreation. Mr Steve also told me that although he
accepts abortion as a right of women, he won't encourage his
partner to abort his offspring.
Contrary to the above case, the following case shows somewhat opposite frame of thought.

Ms Kelly is 44 years old while her partner is 48. They have been together for 20 years. They have three children. It is interesting to see how contraceptive decision changes over time. I present Ms Kelly's case as follow:

I started sexual relation by using coitus interrupts. Realising that this is not a reliable method, I soon changed it to pill. I gained slight increment of weight due to contraceptive pill. In spite of that I took pill for many years. After long time, I began to feel that I had taken too much hormone into my body. I then changed it to IUD. I used IUD for two years. This was also not good method for me. My menstruation was a bit violent. Finally I passed over the responsibility of contraception to my partner. He used condom. I know if we have a big house, my partner wants to add one more child. For me that is impossible. I am too old for that. I want no more child. To be more sure, I now returned to pill. I also feel that my menstruation is a bit irregular for which pill is a remedy.

What did and does pill represent in this case? Effectiveness and availability of the method seemed to determine the choice in favour of pill at the initial period. That was why she changed from coitus interrupts to pill. That was the age when most young girls strive to achieve their career. Now pill represents more of effectiveness and health benefit of contraception.

Women may vary in the strength of their desires to avoid conception and in their perceptions of side effects and benefits of using a particular contraception. In this particular case, contraceptive decision is fully conscious and analytical. This
woman told me that contraceptive decision was predominantly that of her own. She has gained a great deal of contraceptive knowledge from reading materials. That was why she dominated the decision. In between her early and late age, she had also adopted IUD and condom. She might have been tired of taking pill every day. Her expressed reason was fear of the consequences of too much hormone. It is difficult to rule out this perception too. With regard to the present pill, she believes that its hormone content is lesser than the previous one.

4. 4 Individual factors

What makes people choose a particular contraceptive? As already indicated, there are certain background variables that can influence people's perception and attitude to use contraceptive methods. But there are also objective reasons that compel individuals to accept certain contraceptive methods. These objective reasons have patterns when examined in detail. Based on the discourses obtained from the respondents, the following generalisations are constructed:

(A) Contraception as treatment of disorder

Five female respondents have menstrual cycle disorders characterised by heavy, frequent, prolonged or irregular menstruation. Consequently, one young girl has developed iron-deficiency anaemia. Some also have ovulation-related symptoms such as pain or mid-cycle bleeding. The prescriptions of oral contraception is obligatory to abolish, markedly reduce or alleviate these disorders. There are respondents who have such cases and use oral contraception. Although this is one of the established non-contraceptive benefits, it strongly influences contraceptive choice and decision making process too. Most young girls and aged women have used oral contraception on this ground.
Ms Gloria is among the young girls who has similar case with oral contraception. She is now twenty five years old. She started using pill at the age of seventeen for clinical reason. She did not start yet sexual intercourse at that time. Her menstruation was too often, too long, heavy and irregular during every cycle. Because of this she has developed anaemia. Besides this, she had pimple and rashes on her face. She explained the situation first to her parents. They advised her to consult the family doctor. Then the family doctor prescribed her oral pill as a treatment but later when she started sexual relation she continued to use the same pill as a contraceptive method for the prevention of pregnancy.

The other young girl was Ms Mary who has similar history. I asked her when and how did she start using the oral contraceptive pill:

I think I was seventeen years old when I for the first time started using pill not for contraceptive purpose but for treatment reason. I had an irregular and painful menstruation. I have a sister who had the same problem. She used pill as a treatment. She advised me to take pill. Then I went to the family doctor. He prescribed pill for me. I started using pill on this account. After one year, I had a boyfriend with whom I started sexual relation. I continued to use pill as a contraceptive method as well.

People with such kind of disorder have positive attitude for contraceptive pill.

(B) Change of a contraceptive method to a more reliable method
Most adolescents start sexual intercourse using condom as a means to prevent both unintended pregnancy and sexually transmitted disease. Soon or later some of them will understand that condom is not a reliable method for pregnancy protection. They will learn that condom can easily get broken or slip off during intercourse, making them vulnerable to the risk of pregnancy in the early life of their age.

Because of some hardly controllable sexual feelings, people cannot be diligent in the use of condom. They sometimes do intercourse without protection and put on condom when their orgasm is about to come. One of respondents who had studied medicine for six years had committed such a mistake and his partner became pregnant. That pregnancy ended in induced abortion without his prior knowledge. Because he was not around at that time. He told me that if he was around at that time, he would have convinced his partner to carry the pregnancy to its full term. So he learned that if one has to use condom for contraceptive purpose, it must be with the feeling of responsibility to prevent the risk of pregnancy.

Several adolescents who have been using condom as a contraceptive method pointed out that they often visited doctors for morning after pill. One respondent explained that he has been to doctors four times for morning after pill with his different partners at different times. Because of such high risk of unintended pregnancy involved with the use of condom, some young adolescents who have zealous ambition for career development have switched to a more reliable method such as pill.
(C) Perception of contraceptive side effects and personal predisposition

On the other hand, some users of contraception have had several reasons for shifting from one contraception to another. The side effects of the contraception and personal predisposition about the methods are some of the reasons. For instance, informant Judith has explained this and other situations as follows:

I started sexual relation with my first partner using contraceptive method pill. Pill was prescribed to me by my doctor. He did not explain much about the method. I accepted the method without any question. Because I thought he is a professional. I have had a strong trust in doctors. It was also a common method used by most women at that time. It was just normal to ask for pill as a contraceptive method. I did not think of other methods. My knowledge about the pill was that it was an easy method to take and effective method to prevent pregnancy. I was not aware about other methods as such at that time. Besides, my doctor did not inform me about other options and the side effects of the pill. I did not discuss about my contraceptive method with my partner and other people. Because I thought it was my responsibility. I took pill for three months and discontinued to have a child. I always have had depression and headache with pill. But this was not clear to me during those early periods. In spite of this problem, I resumed using pill after I born my first child. I continued using this method even after my second child while feeling the same problem. I then realised that this method was not good for me. I also developed a feeling that I have taken too many hormones in my body. I finally told to my doctor that I need a method which is not hormone. He advised me to take IUD instead of pill. After I changed the method, I had
better health. But I had three major problems with IUD too. These were moral, sexual and health related problems. My moral problem emanates from the way IUD prevents pregnancy. It destabilises conception before it implants into the uterus. I feel this is like killing life. So I always feel guilty with this method. My health related problem was that I always had pain during ovulation since I started using IUD. I used IUD for ten years for the fact that I could not find better option. Latter in my life I divorced my husband and found another partner. I am still with my second partner. In our sexual relation, he has disliked the method I used to. His complain was about the small thread attached to the method which he had felt during intercourse. He had tried condom for about three months. I had disliked condom. I don't like the interruption during sexual relation to put on a condom. It was not easy for me to resume my sexual mood after the break. Since my partner did not like the method I was used to, I asked him to take the responsibility of contraception by accepting sterilisation. However, he was not ready to accept sterilisation not because he needs more children but simply he considered the operation as something that reduces his manhood. I asked him to take the responsibility because I know that the operation is easier for a man than for a woman. His refusal of the operation has made me to be sceptical for all the good words he has been using to express our love. Eventually I became sterilised. After that I have had heavy menstrual cycle.

This long case of a woman indicates that most often, women switch to a different form of contraception in their contraceptive history. The change of contraceptive methods partly depends on the individual's beliefs and predisposition about the consequences of contraceptive use. From this perspective, acceptance and effective use of a contraceptive method depend on the particular properties a person attributes to the method and
not the real consequences. Some of the respondents expressed frequently that they are tired of taking pill every day, that is 'pill fatigue.'

In the case of this particular woman, tubal legation was her last and permanent contraceptive choice. The symbolic interpretation of this last method may suggest some important dimensions underlying the positive decision for the method. There are some background situations that influenced her final decision. She was 42 years old at the time of sterilisation. She has already four children. She does not have a desire for more child. She has already tested pill, IUD and condom. She does not like pill and condom while her partner does not like IUD. She looks still sexually active woman. From these background situations, it is most likely, to conclude that contraceptive effectiveness, sexual pleasure and health considerations were the dominant influencing factors in her decision. I tried to assess if there was any social pressure that she referred to for approval of her method choice. She claimed that it was her independent decision with slight involvement of her doctor.

Interesting enough, most of the respondents deny the involvement of other people in their contraceptive decision. But I found that some of them gather a lot of information from peer groups prior to adoption of their method. I learned this in the informal discussion when they talk a lot about the contraceptive experiences of other women.

Sexual feeling is sometimes hardly possible to control. Especially, when the probability of the occurrence of an event is not definitely known, people will take the risk, allowing feeling to overtake their sense of consideration and logic.

The following case shows this idea: "I was not at good relation
with my partner. I stopped using pill assuming that I would not have sexual relation with him. I decided to abstain from sexual contact with my partner. But at one point in time we resumed sexual relation without protection and I became pregnant unexpectedly."

She considered that pregnancy as a big threat to her educational career. After pondering over the matter, she resorted to induced abortion.

4.5 Social factors

Another approach concerns with the impact of others on the individual's contraceptive choice. In this view, the decision to use a contraceptive method takes place within the influence of social pressures (such as the partner, family members and family doctor). Thus, though a person's contraceptive use would be determined primarily by his or her own decision, the degree of support from important others (e.g., parents, friends, partners) is crucial to enforce the decision.

(A) Male partner involvement

With the change of partners women also sometimes change their method of contraception. In the case of the above example, Ms Judith, had changed her contraceptive method from IUD to condom and then to tubal legation (female sterilisation) because her second partner did not like the small thread on IUD.

However, this study indicates that most male partners take the responsibility of contraception and accept the method proposed by the female partners. For instance, Mr Andrew who is now 51 years
old has a wife whose age is 10 years less than him. In their sexual relation he disliked using condom while his wife disliked using pill. They agreed that one of them must be sterilised as a solution to the problem. Both of them were ready to accept the operation. But Mr. Andrew insisted that he has to take the responsibility. His main reason was that he is 10 years older than her. He thinks that vasectomy is appropriate for him. He did not mind if he did not produce a child after that. According to his conviction, in case he dies she can marry or have a partner. In case the new partner wants to have children, she may decide to produce children.

Mr John is a man of old fashion. He prefers coitus interrupts to condom in terms of sexual convenience. But the former method is more risky than the latter in pregnancy prevention. His wife has tried pill and IUD so far and get tired of them eventually. Then she said to him, "I have been taking contraception for many years I am tired of them. Now it is your turn to carry the responsibility of contraception. Use condom." He accepted condom though he does not like it. He said to me, "It is important to share the responsibility." Hence male participation is one factor that influences contraceptive choice and decision either positively or negatively. On the negative side some men don't co-operate with certain methods of women nor with men method. When both of them have equal power of decision, they may adapt different sexual behaviour on common consensus, such as sexual gratification without intercourse. This study indicated that specially young boys try to show a big responsibility towards contraception. Those who use condom as a contraceptive method, use it with a sense of responsibility. They involve themselves in the discussion about contraception choice with their partners. One young boy told me that many of his peer groups use such kind of the responsibility as a sign of smartness to attract girls.
A young respondent of 25 years confirmed this idea. I asked her in what way her partner shares the contraceptive responsibility. She responded to the question in the following way:

I usually take my pill in front of my partner. But sometimes I take it in the kitchen deliberately to see his reaction as a responsible person. In that case, I saw him several times trying to remind me. Sometimes there will be no pill around. There is no condom either. Without knowing the absence pill or condom, we sometimes awaken in the middle of the night to enjoy ourselves. But as soon as we learn that our contraceptive tools are not there, we fall back to sleep. I think that is sharing responsibility and I love my partner for his co-operation in this regard.

(B) The influence of others

A few respondents do seek the support for their contraceptive choice from partners, mothers, sisters and peer groups. One female respondent consulted a lot of people before adopting IUD as a contraceptive method. But even then she said that IUD was chosen by her own decision. According to her explanation, the various people she allowed to discuss about her method were not her referent groups. In this study, the influence of others on the contraceptive decision seems to be very marginal. The decision is predominantly that of women. Some women even don't involve their partners and doctors in their contraceptive decision.

Dr. Hannie is ambivalent to believe in the idea that contraceptive acceptance in Holland is based on free choice:
Of course every body has the right to free choice of contraceptive methods. However, there are not sufficient enabling situations. Ironically, most family doctors prescribe contraceptive pill to their clients. This is a pity. Because there are other known good methods as well. Nonetheless, many family doctors don't have technical know-how about various types of contraceptive methods. They think that pill is the best contraceptive method for all the people. They know some thing about contraceptive pill compared to other contraceptive methods. Prescribing contraceptive pill is very simple. If you start to discuss about other methods, it will take much more time. Partly it is because of this that they prescribe pill. This day in Holland young girls start sexual relation at early age of 15 and 16. Pill is a good method for this age group. Because most of them have irregular menstrual cycle for which pill is a treatment. On the other hand, it is not good that women are not given choices like IUD, Injectables, and other methods as well. To what extent contraceptive decisions are free from others' influence? The nature of information given to youth, for instance on youth magazines, is pill oriented. And if most actual users are taking pill, there is a bias possibly for potential users to begin with pill contraception as their method of choice. The same is true on women's magazine. So the information they can get from their doctors, mothers, peer groups, and magazines are about pill. If you are encircled with information of many people taking pill, then there is a big influence to begin contraceptive usage by taking pill.

(C) Contextual factors

Individual's contraceptive behaviour is also affected by and related to the contextual factors in which they live. For
instance, contraceptive decisions are influenced by the perceived educational, labour-force and other opportunity costs of unintended pregnancy.

In Holland, the prevalent societal norms support small family size, advanced educational career and self-reliance in life. As explained by respondent Ms Gloria, producing children before achieving major goals in life, would be a big surprise to the community. Another contextual pressure that influenced her contraceptive decision is the contraceptive behaviour of her peer groups. All the people in her peer groups were using pill and condom in combination or either of the two. She said, "I know no people using other methods other than these two." The risk or cost of unintended pregnancy in such society may also influence to use highly effective method such as pill.

Grady et al (1993:6) have hypothesised that in the US communities with high socio-economic status as measured by housing values, have norms that place a high value on both individual consumption and investment in the education and well-being of children. Such norms increase the use of effective contraceptive methods. Because it is very difficult to raise many children to the expectation of the society.

In this study, although the male partners of two families want to add one more child, the female partners refused to accept putting forward the limited number of rooms and expensive educational expenditures as the main constraints. It is good to examine the reasons given by of one these female partners. Her contraceptive history follows this order: coitus interrupts, pill, IUD, condom and now pill. I asked her why she used contraceptive method and especially pill now. She said: 
I have been out of work for ten years raising children. Now I have to work. Our country is small. We cannot keep on producing children. Now we don't have good money and big house to add more child. For this practical reasons I don't have a desire for the fourth child. I came from large family size. We are nine sisters and one brother. I know what the feeling of sisters and brother is. Our generation is not that of kind. Our situation does not allow us to do that. We have to raise our children to the expectation of our society. That is a difficult and expensive task.

In a society where life is more of competitive nature, large family size does not worth importance. The minimum standard of life for most of the people is set by the norms of the society. In the above example the expectation of the society and the real life situation in the society such as insufficient money and rooms, expensive education system are some of the contextual factors that call for the use of effective contraceptive method.

Mr Robert is a male respondent. He has a perspective in which he believes that the norms of the society have influenced his reproductive career somewhat negatively:

I and my wife have prevented pregnancy for many years of our reproductive age especially after we have got one child. This happened to us partly because of egoistic and self-centred life style imposed on us by our society. We frequently went out to enjoy ourselves in our leisure time instead of thinking about family life. This was also a normal practice, at that moment, among certain group of people in my community. I was especially scared accepting the responsibility of raising children. I frequently postponed the idea of having a child. Our society also disapprove having children before finishing study and
securing good job. Afterwards, I started to travel to many parts of the world to achieve these goals (that is educational career and then good job). These are some of the excuses people like me can give with regard to the role of fatherhood.

The idea of this respondent indicates that the role of parenthood and self development through higher education are incompatible. When there is a gain on one end there might be a loss at another end. It seemed that the cost of losing education worsens than the cost of losing parenthood.

Personality variables such as introversion as opposed to extroversion and inner directness as opposed to other-directness and pessimistic views of the world (beliefs that the world is becoming over populated and under nuclear threat) has indirect influence on fertility and contraceptive decision too. The following case may illustrate this point.

Mr Bob is 25 years old. He has pessimistic view about the future of the world. The premises for his pessimism is the effect of cold war and population growth. He believes that if children don't have good future, they should not be brought to this world. He says, "The world is overcrowded degrading the environment. The world is also under the threat of nuclear war. The politicians are not doing what they have promised to do. So I don't see the importance of adding children to this world." Currently, he has no stable partner.
5. SUMMARY AND CONCLUSION

The main objective of the present study has been to identify the influencing factors in contraceptive decision making process. In an attempt to achieve this objective 23 individuals were interviewed using open ended questionnaires. The summary of the findings and the recommendations are presented in this section.

5.1 Summary of the findings

In this study, data on individual characteristics including age at marriage, religion, education, marital status, age at first child and career development have been collected to examine the effects of these variables on the variation of contraceptive decision making process.

According to the result of this study, religion and education don't seem to have significant impact on the variation of contraceptive choice. Most of the respondents don't have known conventional religion. Religion does not appear to be the focus of their life.

Most of the respondents are attending or have completed education at university level. But they acquire family life education prior to university at high school level. So that every body can get substantial amount of contraceptive education at early age of their life from educational system of the country. Furthermore, reading materials on contraception and reproductive system are easily available to every body who wants the detail knowledge and information. Hence, religion and education don't seem to account, as they do in most developing countries, for the variations of contraceptive decision and use, at least, among the study groups.
Given the nature of partners or couples relationships in this society, age at marriage and marital status are not good variables for analysis of this study. Rather stable and unstable relationships between partners or couples are better concepts to reveal some linkages of these variables with contraceptive decision making process.

Partners with stable relationships appear to have more knowledge and experience about contraceptive methods than who have unstable relationship with their partners.

Most of respondents with stable relationship have used less reliable methods of contraception during their initial stage of sexual relationship and between pregnancies as a means for child spacing. The former situation may indicate lack of experience while the latter may show haphazard fertile decision which may lead to adoption of less reliable contraceptive methods. This in turn may imply that couples have not accomplished their fertility desire.

On the other hand when the relationship is unstable, both partners are more cautious about unexpected pregnancy. Thus, they tend to use more reliable contraceptive method than partners with stable relationship. This study shows that the type of relationship (stable or unstable) is more important than the frequency of intercourse in determining contraceptive choice.

Age at first child and career development have strong impacts on contraceptive decision making process. In this study, the mean age at first child is 30 years. The ideal mean age for the first child among respondents with zero party is found to be 29 years. The ideal mean age may indicate the tendency to accomplish
desired number of children as early as possible. In congruent with this idea, most respondents (13) after 35 years of age use reliable contraceptive methods such as pill or sterilisation to prevent unexpected pregnancy.

Women place careers ahead of motherhood and postpone the birth of their first child until they are in their late twenties or early thirties.

The expressed reasons for current use of contraceptive method is to regulate menstrual disorder, to have the pleasure of sex, to prevent pregnancy and STD.

Most respondents know the name of the major contraceptive methods including pill, condom, IUD, diaphragm, surgical sterilisation. Other methods such as injectable, norplant, persona, female condom, cervical cap, foam tablets, sponge et., are seldom mentioned.

Contraceptive policy in Holland seems to overlook the right to informed choice. Pill and condom are over propagated. Other barrier methods (diaphragm and cervical) and spermicides (foams, jellies, etc.) have not received due attention. Some respondents suspect that pharmaceutical companies might have influenced the propaganda machine towards pill and condom.

Although a wide range of methods and information is available, it is hardly believable that actual and potential users are making use of them. Thus, contraceptive users lack complete information about all methods: how the method works, its side effects, contra-indications and side benefits.
People's attitude towards a method in part depends on the perception they have about how the regime works. Pill has good acceptance among those who have menstrual irregulars or disorders. Most people have more negative attitude for the methods they have never used than for the methods they are now using. In spite of the negative attitudes from the people, pill is the most widely used method.

Universally, women and men would like a method that is safe and effective. Side effects and health concerns (particularly with respect to hormonal methods) and method failure (particularly with respect to barrier methods and periodic abstinence) are the major reasons why women discontinue or don't use certain contraception.

Side effects encountered by the users of contraceptive pill include weight gain, headache, depression, and amenorrhea. Some of the advantages of pill mentioned by the respondents include: it is easily available, increases sex freedom, has health insurance, has side benefit, is reliable method, reduces dependency, does not involve body manipulation, provides power to women.

Condom is the second most favoured method. All respondents have tried condom either to prevent pregnancy and STD or both.

Individual perspectives and preferences vary widely and withstand generalisation. Women's and men's needs and preferences for contraception change over time and vary with the person's stage of life.

People's perceptions and preferences about contraception are
largely dependent on cultural values and norms the society has for birth controlling technologies.

The analysis revealed that the choice of a particular method is influenced by the perception of the individual couple, and of the society at large, regarding different methods.

The variation in the patterns of contraceptive use across individuals and couples highlights the complexity of contraceptive decision. The diversity of the influencing factors associated with the decision ranges from individual's perception and experience to the societal level of established norms.

5.2 RECOMMENDATION

Family doctors must have contraceptive information and training needed to counsel their clients.

The media propaganda should maintain fairness and balance in information dissemination about each contraceptive method.

The right to have access to the information and means needed to exercise voluntary choice by the clients should be assessed in order to improve the reproductive decision making.
REFERENCES

Beckman, Linda J.
1978 Couples' decision-making processes regarding fertility.
    Social demography. Academic Press: New York,
    Sanfransisco, London.

Condelli, Larry

Delft, M. van & Ketting, E.

Fishbein, Martin
1972 Toward an understanding of family planning behaviours.

Gement Amsterdam
1998 Amsterdam city guide.
Grady, William R., Klepinger, Daniel H. and Billy, John O.G.

Hordon, Anita P.

Hordon, Anita P. and Schafsma Evelyn

Hordon, Anita P. and Elizabeth Hayes (ed.)

Heeren, H.J.
Jaccard, James

Jaccard, James, Helbig, Donald W., Wan Choi K., Gutman, Majorie

Ketting, Evert
1995 The family planning and sexual revolution in the Netherlands. *Health matters: Public health in north-south perspective*

Khanna, J. Look, Van P.F.A Griffin, P.D

Levie, L.H
1990 De verandering in de medische attitude ten aanzien van seksualiteit en procreatie in de loop van de laatste 50 jaar (Changes in medical attitude concerning sexuality and procreation in the past 50 years). *Nederlandse Tijdschrift voor Geneeskunde*, 134(51): 2472-2475
Moors, H.G

Negewo Tilaye

Knitter, Mark and Nichter Mimi

Rudolf, Jacquiline

Senanayake, Primila and Potts, Malcolm
Sciortino, Rosai and Hardon Anita P.
1994 *Fertility regulation in Netherlands from a north-south perspective: A review of studies and annotated, selected bibliography.*

Townes, Brenda D., Beach, Lee Roy Campbell, Fredrick L.

United Nations Population Fund
1997 *The state of world population*

Wernner, Paul D. and Middlestadt, Susan
1979 *Factors in the use of oral contraceptives by young women.* *Journal of applied social psychology.* Vol. 9(6):537-547

APPENDICES

Appendix 1. Summate of the interview

Care is now 37 years old. She started sexual relation without intercourse. The reason was that she did not like pill and her first partner did not like condom. She began to use condom with the second or present partner. She has stable relationship with
her partner. She got her first child at age of 29. She has two children from her present partner. Her ever and present method of contraception is condom. She has not changed the method so far. She has not encountered any contraceptive consequence and failure so far. She got her last child a bit later than her expectation. That has not worried her. Because she has not liked strict child planning. Her contraceptive attitude is negative except for condom. The basis of her argument is that there no clear cut information as to the consequences of pill and IUD. The decision to use condom is that of both partners. She knows all contraceptive methods including pills, IUD, injectable, norplant, diaphragm, female condom, sterilisation (male and female) and traditional method like coitus interrupts. Sources of her knowledge are her mother, school, books etc.

Steve is now 39. He got his first child at the age of 32. He has experienced various contraceptive methods on his partners such as pill, diaphragm, IUD, and condom. His attitude about contraception is ambivalent with more of negative attitude especially toward hormonal contraceptive and IUD. He believes that these methods are potentially dangerous for the health of women. According to his perspective the artificial hormones change the natural hormones in the body. IUD is like poison. The risk of these methods worse than the risk of pregnancy. He is currently using condom. He has a desire for one more child. But his partner refused him because she believes the rooms are not ample to add more child. He decided together with his partner on the choice of contraceptive method. They did not allow outsiders into their contraceptive decision. He feels equal responsibility for contraceptive use.

Andrew is 51 years old. He got his first child at 42. He is quite and humble person with slight feeling of shy talking
about sexual matters and contraception. He is married at age of 40. He has two children nine and seven years old. He used condom as a means for child spacing. The use of condom was suggested by his wife to him. In spite of his negative feeling for condom, because of the interruption during sexual intercourse, he accepted it. After the second child he became sterile by operation. He did not want to add more child. He accepted the operation because he was ten years older than his wife. The dominant decision maker seems to be his wife. But she was also volunteer to accept sterilisation. He believes pill has health side effects. He has no much information about various contraception. He has no complaint with the operation.

Kirista is now 40. She born her first child when she was 32. She started sexual relation using contraceptive pill. Pill was her own choice though prescribed by doctor. She read about pill and IUD at that time. But she did not like IUD. She believed that IUD could cause inflammation and sterility. Later, she changed her method to condom. Because she began to feel that she has taken too much hormone into her body. Then for the first time condom failed and she became pregnant. That pregnancy led to present marriage. Unfortunately she lost the pregnancy after 11 weeks. Now she has two children. She does not want to have the third child. So her husband became sterile. She did not want to continue using condom after the second child. Because she knows that condom is safe in terms of health but not effective in pregnancy prevention. Her husband took the initiative of becoming sterilise. Otherwise she was also ready to accept sterilisation.

Gloria is 25 years old. She started using pill at the age of 17 as a treatment for irregular menstruation and some rashes on the face. Pill was prescribed to her by family doctor. Later, when she started sexual relation, she continued using pill for fertility prevention. As time goes on she began to change sexual partners. This fact led her to adopt condom, in addition
to pill, to prevent sexually transmitted disease. Still she has not get stable partner. Though now she begins to feel that she is tired of taking pill, she would like to stick to her method until she achieve her educational career and find best partner. She does not like contraceptive methods that create dependency on medical professionals for application. She believes that she has made correct choice of methods. Because she said, "pill allows me to postpone my period when I don't want it. It is also helpful in reducing an excess blood flows through menstruation." For her the advantages of contraception outweigh its disadvantages.

Judith is now 42. She has four children: two from her second partner and the other two from her first husband. She had encountered one induced abortion. This unexpected pregnancy was occurred because had a conflict with her partner she stopped using any method at that time. She born her first child at age of 20. Her first method was pill. That was prescribed by doctor. She had depression and headache every time she took pill. Despite this feeling, she took pill for a long period of time until she changed it to IUD. She had a moral problem with IUD. She believes IUD aborts pregnancy. She has pain during ovulation since she started using IUD. Her present partner does not like the small thread on the IUD. Because of this she changed her method to condom. She does not like condom. She tried it for three months. She absolutely dislikes the sexual break caused by condom. Then she asked her partner to be sterilised. He refused to accept the method. Then she undertook the operation of sterilisation. At the same time she felt that her partner is not a responsible person for contraception. Since then her love for him has decreased.

Natasha is 25 years old. She started sexual relation at the age of 17 using condom as contraceptive method and also to prevent STD. She used condom because it was easy to get. After a while she began to use pill in combination with condom. She does not
want to have children before finishing her study, securing good job and finding stable partner. She has positive attitude for pill. She believes pill enables her to reduce pain during menstruation and also to explore the pleasure of sex any time. She feels condom is expensive. The basis for choice of contraceptive pill was that pill has health insurance coverage and it is also a common method among her peer groups. Though she knows IUD and diaphragm, these methods are not available to her. She does not remember how the pill works.

Mr Segal is 36 years old. He started sexual relation at the age of 16 without any protection. Before his partner became pregnant, he broke the relationship. His second partner was using pill and sometimes the traditional method called rhythm. But at one time his partner messed up the system of menstrual cycle and she became pregnant. Finally, she aborted the pregnancy although he was against it. His third partner was using pill and when she was not on pill, he was using condom. With his present partner, they used for sometimes condom. Currently, they use no contraceptive method. Because they want to have a child. Generally, he is in favour of contraceptive methods. He believes they are important to prevent unwanted pregnancy and sexually transmitted disease. But he does no know much about contraceptive consequences. He feels condom is expensive.

Ms Eileen is 36 years old. She started sexual relation when she was 18 years old using contraceptive method pill. Pill was her own choice. She decided to use pill because it was easy to get and also to stop when not needed. The doctor and her partner had less influence in her contraceptive decision. She was a little bit depressed and unhappy with the method. Her weight increased. Then she commenced feeling uncomfortable with this method. She scared about the side effects of the hormone. She
had strong ambition from as early as high school. She wanted to have an employment in United Nations Higher Commission for Refugees UNHCR). Partly, I think she adopted long acting contraceptive method: IUD. But before deciding to use this method, she tried to put together the pros and cons of various arguments made by people. She had discussed about this method with doctor, her mother, her friends and even the mothers of her friends. Her friends were also looking forward to her experience to use the method for themselves. Finally, she accepted the method for ten years. Nevertheless, she became pregnant while the method was there from her partner of 12 years. At that time she has already achieved most of her careers. She has become successful to get employment in UNHCR and served in African countries. After all these, she was not ready to start her reproductive career. Still she had not found a suitable partner. unfortunately nature decided for her. She said to her self, "If it comes, it comes. Okay I will look after my child." She recognised her pregnancy after ten weeks. Then the IUD was removed. However, the pregnancy could not reach its full term. She had a miscarriage of three months. Since then she used condom for both pregnancy and STD prevention. Now has found a reliable partner. Currently she uses no contraception. Because she wants to have a child.

Mr Dave is 33. He started sexual relation when he was 17. He was using condom and his partner was taking pill. They combined the two methods to prevent pregnancy and STD. Both methods were easy to obtain. With his second partner he did sex without protection. On the next day, they went to a doctor for morning after pill. After that he was using condom. His partner did not like to use hormonal contraceptive. His partner is a Gay and now he is totally a Gay. He uses Gay condom.
Ms Janette is 28 years old. She started sexual relation at 22 using condom. The basis for the selection of the condom was that both partners were not sure for how long their relation would last and besides it was easy to obtain. With other partners she used sometimes pill and sometimes combining condom. Currently she use no method because she has no partner. She thinks that taking hormonal contraceptive over a long period of time might have health consequences by complicating the whole body function system. She had gained a lot of weight for the first ten days of taking pill. Her attitude on contraceptive methods is ambiguous. On one hand, she believes these technologies are important for family planning and treatment of menstrual disorders on the other hand they are health hazards causing breast cancer, heart failure and so on.

Mr William is 42 years old. He is currently married. He got his first child when he was 28 years. He started sexual relation at age of 16 without protection. His partner did not become pregnant because their sexual relation was not frequent. Most of his partners were using pill as a normal practice of the day. His involvement was limited. Although he did not like condom, he use it for sometime just to share the responsibility of contraception. But now his wife is using pill as contraceptive and treatment of menstrual irregularity. He tends to say that the norms of reproduction in Dutch society are too much repressive. According to his explanation, the norms of the society support small family size and egoistic career development. Further, the society expects from each individual to advance education to university level and beyond, to tour the world and enjoy life but not to procreate children before achieving these goals. He believes contraceptive technologies are essential for developing countries where population growth is endangering socio-economic development and environmental improvement.
Ms Margrit is now 49. Her age at first child was 22. She started sex at 22 without protection. She had pregnancy of three months when she was married. She has three children from her husband. After the first child, she commenced to take pill to prevent pregnancy. At that time she started educational career. She gained a lot of weight from pill. She was so sick that she could not continue to use pill. Her doctor advised her to take IUD. She heard many negative expressions about IUD at that time such as infection, bleeding and infertility. She did not accept the method. Diaphragm was not a practical method for her. Then she condom, sponge and cream. After her born of the second child, she was weighting for menstruation to take IUD. But without her knowledge and seeing her menstruation, she became pregnant the third child. That unexpected pregnancy was her last child. In the same way, after her delivery of the third child, she became pregnant the fourth unexpectedly. At that time she started university education. In favour of her educational career, she aborted that pregnancy. After abortion she immediately took IUD. It was a good method she had ever found. She resented for not taking it as early as possible. Her husband was not co-operative in her contraceptive methods. She believes that contraceptive technologies are developed to control women's reproduction. These technologies are also damaging the health of women. On the other hand, she accepts the contribution of contraceptive technologies towards women liberation and freedom. According to her notion, the family planning policy in Holland is suppressive for the fact that it preaches small family size as result of which the Holland people have lost the value of family.

Ms Elizabeth is now 22 years old. She started sexual relation at the age of 21 using condom. She used condom to prevent pregnancy and STD. She was not sure whether that relation would be stable or not. She had discussed about the method with her
partner at that time. Condom was their choice. Her attitude toward the risk of pregnancy was not strong. In case condom breaks, she would opt for morning after pill. If she becomes pregnant for long duration without her knowledge, she won't easily abort. She used condom with second partner also. She fears AIDS than pregnancy. At present, she has no partner so that she don't use any method. Her attitude for pill is positive due to its effectiveness and simplicity to administer. She does not fear contraceptive consequences especially that of pill. She knows other methods like diaphragm, sterilisation, and calendar. Her sources of knowledge are school, leaflets and friends. Before child bearing, she wants to finish her university education and find the right partner. She likes large family size. She has three sisters. She found that to be positive. When she was 21 she used to say by 22 she would have children. Now she is 22. She has no child. If she finds the right partner, she would have children by next year if not she would opt at the age of 28 or 30.

Ms Veronica is now 27 years old. She started making love at the age of 18 without intercourse. She started sexual relation at the age of 22 using condom. For her, condom was easy method to get. A year latter, she switched to pill for practical reasons. She wanted to plan her period. She consulted her partner and sisters before administering the pill as her method of choice. They all approved her choice. The doctor prescribed pill for her. She also uses condom with a new partner to prevent STD until they know each other. She knows other methods such as diaphragm and IUD. Her attitude for diaphragm is negative because her mother had become pregnant while using this method. According to her opinion, IUD does not have good reputation. Her sources of knowledge are school and her sisters. Presently, she uses no method. Because she does not have partner. She has not encountered any contraceptive side effects so far.
Mr Mike is now 23 years old. He started sexual relation between 16 and 17 using condom. His partner started sexual relation using pill before him. For one and half year, they used both pill and condom. The use of condom was sporadic. He disliked condom for the fact that condom creates break in the sexual mood. With his present partner, he uses condom and calendar method. He feels and wishes to be responsible for contraceptive use and child care.

Ms Michelle 47 years old. She commenced sexual relation at the age of 20 using coitus interruptus as a contraceptive method. It is highly unreliable method to prevent pregnancy. She then became pregnant. Her partner was conservative Catholic. She married him at 22. She has two children from him. They have never been in agreement on the use of contraception. She divorced him at the age of 35. She had five pregnancies, out of which three were miscarriages. After the fifth pregnancy, she used IUD. But she had infection from IUD. She then switched to pill without the knowledge of her husband. Her husband was too Catholic and did not share any contraceptive and reproductive responsibly. Eventually, they divorced through hard way. After that she became sterilised at 35.

Ms Milena is now 23 years old. She started sexual relation at the age of 18 years using contraceptive pill. Although pill was prescribed to her by family doctor, the method was also her choice. She selected the method because she knew many people use pill and pill is reliable too. She gain weight when she use the pill. She consulted her friend who was using pill. She scares how pill controls the date and time of menstruation. Then she switched to condom. She knows condom is not a reliable method to prevent pregnancy. As the result, she visited doctor twice for morning after pill. Still she uses condom. She does
not like the way people plan children. According to her, some people plan children just like buying a car whenever they want.

Mr Bob is 25 years old. His future career is to find good job and make good living from that. He does not believe of adding more children to this world. For him, the world is overpopulated and under threat of nuclear war. He started sexual relation at the age of 20 years. His partner was using pill while he was using condom in addition to the pill. Presently he has no partner.

Ms Mary is 24 years old. She commenced sexual relation when she was 18 without protection. Later, she did test for HIV/AIDS. She had painful and irregular menstruation for which pill was prescribed to her. Her sister who had the same problem advised her to visit doctor. She always gain two kilos when she takes pill. She read about the pill and found that the gain of two kilos as normal behaviour of the regime. She has no other side effects. She assume that her partners somehow feel responsible for contraceptive use. She fears the risk of pregnancy than HIV/AIDS. If she becomes pregnant, she won't hesitate to abort. If this is in her late age of 27, 28 or 30, she carry the pregnancy to its full term. But now not only due to her age but also she wants to finish her education and find good job before becoming a mother. Her attitude for pill is positive. She believes every body should have access and choice in contraceptive methods. According to her opinion, pill is loyal, effective, reliable and convenient. It also gives her independence to control her own body. Her knowledge about contraceptive methods is quite substantial.

Mr John is now 48 years old. He started sexual relation when he was 17 using coitus interruptus method. He had not had any discussion at that time with his partner about contraception.
He has three children from his partner. Though he dislike condom, he used it for child spacing. He shares the responsibility for contraception and for child care. Still, he wishes to add one more child though his partner disagree due to her age and lack of enough rooms. His partner presently uses pill.

Ms Kelly is 44 years old. She started sexual relation at 20 using coitus interruptus. Later, she changed the method to pill. She used pill for many years and eventually felt that she has taken too much hormones into her body. Then she changed to IUD. She used IUD for two years. She believes that her menstruation was heavy when she was using IUD. Then she passed the responsibility to her partner for sometime. He used condom. Now she uses pill mainly for two reasons, that is her age and menstrual disorder. She also wants to work. She has good deal of knowledge.

Mr Robert is 51 years old. He commenced sexual relation without protection. He did not involve in the discussion of contraceptive use with his partners.

DOCTOR'S PERSPECTIVE

Since how well each method works for any individual woman or couple is hardly known with certainty, most clinicians believe it wise to tell the users the failure rate of the method.

What is your responsibility in Jacob Aletta Foundation?

I am responsible for implementation of protocols we are using
in our clinics.

What kind of people visit your clinic?

Any body can visit us, both men and women, young and adults. We provide them with medical and contraceptive services along with STD examination and treatment, all kinds of discharge complains, popsmear, and sex therapy.

What kinds of contraceptive do you provide?

We have all kinds of contraception here in Holland. The only thing we don't do is surgical sterilisation. We refer people to Hospitals when they come for this method. We have a variety of pills, condoms, The Dutch cup, or diaphragm (that was promoted very much before 100 years by a Dutch woman but currently it is not a famous method), various types of IUD, Injectables (not famous or well known), Norplant (is not in the market in Holland) Infanon (is going to be available in March 1999, it is one straw for three months), Persona.

Why diaphragm is not a famous method?

Why people like one method not other method depends on many factors. For Dutch woman the importance of method depends on whether it is a reliable method or not. So people think that this method is not reliable. Furthermore, it is not an easy method to use. It needs some kind of training. It is also a bit messy method. So for a woman using contraceptive method, reliability is the most important thing.
What is persona and how does it work?

This is a device used to help women know their fertile day. If they know their fertile day they can abstain from intercourse. There is a little computer in the device. In the computer there are daily compiled measurement of urine of many women. The computer knows how the hormones in the cycle of normal women fluctuate. It measures oestrogen and its age in the urine. By measuring oestrogen it can estimate the beginning of fertile period in the cycle and by measuring its age and lutinizing hormone, it can estimate the end of fertile period. The small computer has three lights, namely, red, green and orange. Red means fertile period, green means end of fertile period, and orange means urine test.

Do you believe that contraceptive acceptance is based on free choice?

To some extent it is not based on free choice. Contraceptive pill is mostly prescribed by family doctor. It is a pity that other good methods are not well known. Many family doctors don't know about contraceptive methods. They think that pill is the best contraceptive method for all the people. They know some thing about contraceptive pill compared to other contraceptive methods. Prescribing contraceptive pill is very simple. If you start to discus about other methods, it will take much more time. Partly it is because of this that they prescribe pill. This day in Holland young girls start sexual relation at early age of 15 and 16. I also agree that pill is a good method for beginners of early ages and then continue to use pill even at latter ages too. It is not good that women are not given choice like IUD, Injectables, and other methods as well.
What are the main complaints of contraceptives?

Most women are complaining forgetting taking their oral contraceptives. They also complain spotting, bleeding, weight gaining, breast tenderness, headache. Copper IUD is the most complained method for causing heavy blood flows and headache during menstrual cycle. Sometimes people are afraid of having infection and consequently sterility from IUD. But there are quite a number of women who are well satisfied with IUD. In the beginning a lot of women ask to take out the IUD but those who used it for a longer period of time are well satisfied. For Injectables, not used frequently, the complaints we heard are spotting, bleeding and amenorrhea or absence of menstruation. Condoms break or slip off and sometimes smell bad.

How do you manage all these complaints?

Well, if a woman comes here complaining of pill, we will try to consider many things. Does she like pill as a contraceptive method? If we think she likes the method, we will change to other brand of the pill and manage the complain. Sometimes we need to change to other type of contraceptive method. When a woman complains weight gain and breast tenderness and the like, it may sometimes mean getting tired of taking pill. Then we will discuss about it asking whether they like to have children or other type of method. So this has to do with all methods. We do carefully and discuss intensively either to change the method or continue. When a woman using IUD is complaining heavy bleeding and pain, we will take it out. But we always try to check whether it is in a good position or not since misplacing can cause these complains. If it is not in right position, we will take it out and insert new one in correct place. We have
not often encountered infection from IUD. We usually check for infection before insertion. Most complaints are resulted from wrong position or position related problems. The infection rate of women using IUD and not using IUD is the same.

Does the copper on the IUD leak into the blood stream and if so does it have side effect on a woman and its foetus?

It probably does leak into the blood stream as some coppers completely disappear after many years when checked out. However, in some women after ten years of staying in place and taken out, nothing happens to the copper. It just new. The disappeared copper might have been taken into the blood stream. As far as I know this does not have an effect on the health of the women and their foetus as well.

How does IUD prevents pregnancy?

The copper will make the sperms immobile so that fertilisation cannot take place. But you cannot deny that sometimes there will be fertilisation taking place and the second action of the copper is prevention of implantation of fertilised egg. Some people consider this as a form of abortion. It depends on what someone considers pregnancy. For some people pregnancy begins after implantation. So they will not consider copper as abortion method. For some religious women who opposes abortion, it would be a difficult method. I cannot disprove with these group of women that there will be no pregnancy. With other type of copper that contains hormone, I can assure that pregnancy cannot take place because it works by thickening the wall of the uterus too much so that the sperm cannot pass through
uterus.

What is your opinion about affordability, accessibility, and availability of contraceptive methods?

In general terms all contraceptive methods are affordable in Holland situation. But there are exceptions. For instance, for some people condoms are expensive. Certainly female condoms and high quality of male condoms are expensive. Contraception is always a political decision in Holland. It is not easy to include all contraceptive methods in health care system of the country. If it is not in the health care system, one has to pay for it which could be quite substantial amount when added a month and then a year. At moment, it is difficult to get political support for condom to be included in the medical care system. It was with big effort that pill, IUD, Injectables and Diaphragm were included in the health care system. Even one version of IUD is not in the system. But we hope it will be included in the near future. Although a variety of contraception are available in Holland, all of them are not easily accessible to the users due to technical reasons. Many family doctors, are not able to introduce methods like IUD, Injectables and Diaphragm because of lack of knowledge about these methods which are equally important as pill. Some people have to travel long distances to get the method of their choice. This is not an easy task for some people. So when methods are available, they are not easily accessible.

To what extent contraceptive decisions are free from others' influence?

The nature of information given to youth, for instance on youth magazines, is pill oriented. And if most actual users are
taking pill, there is a bias possibly for potential users to begin with pill contraception as their method of choice. The same is true on women's magazine. So the information they can get from their doctors, mothers, peer groups, and magazines are about pill. If you are encircled with information of many people taking pill, then there is a big influence to begin contraceptive usage by taking pill.

What are the dissemination mechanisms of information, education and communication in this country?

There are various mechanisms. We have a number of leaflets for reading and we also receive 15,000 telephone calls each year for information and education. We receive a variety of questions among which contraceptive inquiries are the largest questions. A lot of people can also get contraceptive information from magazines, schools, mothers, doctors, friends etc.

Do you think that people are given reliable and meaningful information concerning how the contraceptive methods work, their health side effects and contra-indications?

As I said family doctors are not good enough to tell about alternative methods of contraception, let alone how methods work, their side effects and contra-indications. Providing reliable and meaningful information is important for a patient's compliance with a method. It will help to increase continuation rate of contraception. In Holland contraceptive discontinuation is not as such a problem compared to other countries. Here women prefer to take the risk of contraception rather than become pregnant. That is why age at child bearing and contraceptive continuation rate are very high though
contraceptive options and choices are not expounded that much. The available information is highly biased towards pill.

Are there any contraceptive rumours that spread among the people which don't have scientific ground?

Yes, there are many myths specially about IUD. Many people say that IUD is not reliable and it causes infection and as well as infertility. There are also some rumours about pill, for instance, some people think that certain brands of pill can cause cancer. All these rumours can influence contraceptive choice.

What do you think are the reasons for a Dutch woman to postpone child bearing to later age?

I think that has to do mainly with educational career. Many people are joining university and they want to finish their study and secure good job before becoming parents. And also people like to travel and see the other part of the world and also do whatever they want to do in life before they get settled as family.

This transcription shows how the availability of contraceptive mix and information can affect contraceptive decision. Information regarding the pros and cons of various contraceptive methods is relevant to make contraceptive decision. Where there is a bias in information dissemination, people's decision connote be free and informed choice.

Questionnaires
Questions related to background variables

1. Can you please explain about your marital status?
2. If you have a partner with or without marriage, how stable is it?
3. If you have changed partner, how often was it?
4. How old were you at your first marriage?
5. Can you please explain about your marital and reproductive history?
6. How many times have you been married?
7. If you have no child yet, what would be your age at first child?
8. How old were you at your first child?
9. What was or is your desired number of children?
10. Have you accomplished according to your plan?
11. What was your plan regarding children?
12. Have you encountered any unplanned pregnancy or birth and how often?
13. What was the cause of unexpected pregnancy or birth?
14. In that case, what was the measure taken?
15. What do you do if your expectation fails and if you become pregnant, are you going to abort or carry it to full term?
16. Have you ever encountered abortion and how often and what was the cause of unexpected pregnancy?
17. What is your present age?
18. What is your religion?
19. What is your completed highest level of education?
20. What is your occupation?
Questions related to contraceptive knowledge, perception, attitude and practice.

20. Please would you tell me all the names of contraceptive methods you have heard so far, be it modern, traditional or natural?

21. From where have you heard for the first time?

22. Can you please explain how the method you have identified prevents pregnancy.

23. What is your attitude with regard to contraceptive technologies?

24. In your opinion what kind of side effects and consequences do contraceptive methods have?

25. What type of contraceptives methods you or your partner have ever practised, be it modern, traditional or natural?

26. What was your or your partners expressed reason for using contraceptive methods?

27. How did you select the method?

28. What methods were available for choice?

29. Do you feel you have made correct choice?

30. Do you think that the availability of contraceptives was or is satisfactory?

31. Do you think family planning providers have given you clear instruction on how to use the methods?

32. In your opinion what motivates people to use contraceptive methods?

40. Is there a method which you can not afford easily?

41. Have you or your partner made any method change? or shifted or discontinued at all? If yes why? Explain.
42. Have you ever been told about the side effects, contraindications and effectiveness of the method by providers?
43. If you assume methods do not have side effects how did you learn that?
44. If you believe there are side effects, how do you balance the advantages and disadvantages of contraception?
45. What type of methods you or your partner presently use?
46. If you are non-user, would you explain why not?
47. When do you think will you begin using contraceptive method?
48. Do you think that someone (your partner, family member, friend, medical doctor) has contributed to your method choice? If so in what ways and how?
49. What was your reaction to the opinion given by others about your method choice?
50. Who was dominant in your contraceptive decision making process and why?

Questions for medical doctors

1. Profession
2. Responsibility
3. Age
4. Sex
5. Can you please explain the types of contraceptive methods currently available to users?
6. Do you think that the currently available methods are safe and acceptable?
7. What is your opinion about the relationship between service providers and users?
8. What are some of the clients' complaints?

9. How contraceptive side effects are managed?

10. Can you please explain the components and quality of services given to clients?

11. What is your opinion about the affordability, availability, and accessibility of contraceptive methods?

12. What other medical services, other than contraceptive distribution, education and communication are given?

13. What is your opinion about contraceptive follow-ups and counselling?

14. To what extent contraceptive decision making is free and informed choice?

15. Do you think that clients select their method of choice without others' influence?

16. Who can have influence on clients method of choice?

17. What are the mechanisms of disseminating contraceptive decision, education and communication?

18. Do you think that the present information, education and communication is sufficient?

19. Do you think that the actual and potential users of contraception are given reliable and meaningful information including the health implication of the methods?

20. Do you think that all available methods are given equal attention?

21. If not why?