Chapter 2

QUALITATIVE ANALYSIS OF TRADITIONAL AND MODERN METHOD USE: THE EXPLORATORY PHASE

INTRODUCTION

An exploratory study was carried out to gather information needed to design the main survey questionnaire. Previous surveys revealed widespread knowledge of contraceptives among Sri Lankan couples, but knowledge was defined as simply having an awareness of the method. The exploratory study obtained in-depth information on knowledge and use of contraception. This section highlights some of the important findings obtained in the exploratory phase.[5]

METHODOLOGY

Three districts were selected as field sites: Ratnapura, Kalutara and Kandy. Two field teams were formed, one speaking Sinhala and the other speaking Tamil. Each team included both male and female interviewers. The exploratory study covered 90 families in the study areas and also included some interviews with local health and family planning officials. The socio-cultural makeup of the sample included rural Sinhalese, urban Sinhalese, Indian Tamils and Muslims.

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5 This chapter draws heavily on research work by Mimi Nichter summarized in a report (prepared for the exploratory phase of this study) entitled "Traditional Practices and Modern Methods of Family Planning in Sri Lanka: Preliminary Report of a Qualitative Study," and research by John Caldwell, et al., (1987), summarized in an article entitled "The Role of Traditional Fertility Regulation in Sri Lanka," Studies in Family Planning, Vol. 18, No. 1, Jan/Feb 1987.

Some basic socio-economic characteristics of families interviewed areshown in Table 2.1. The area in Ratnapura covered 3 villages which were fairly prosperous because of small holdings of tea; practically every family had an income of over Rs. 2000 a month. In Kalutara District, Beruwala Urban Council area was selected. Sinhalese families from the fishing community, families of Muslim traders, and families of lower middle class were selected. The estate in Kandy District included in the study is a private tea estate and all 31 families who were interviewed spoke Tamil. The respondents were well spread over different age segments, work status categories and educational levels (Table 2.1). Ethnic and religious groups were well covered and the urban group was atypically low in terms of female educational attainments and work status.

A total of 101 couples were interviewed. Two types of interviews were carried out - in-depth interviews with husbands and wives, and informal purposive interviews with key figures in the community. Each in-depth interview involved two or three sessions with the wife (by a female interviewer) and one or two sessions with the husband (by a male interviewer). A detailed family profile with special attention to marriage life and family planning was obtained in these interviews. In addition to the selected sample of couples, some other male and female informants were selected for more casual interviews. Community leaders and paramedical personnel, such as midwives, dispensers and Ayurvedic doctors, were also selected for the more informal interviews to ascertain their points of view regarding family planning issues.

In all of these interviews, information was obtained only on certain key themes. The following are the main themes that guided the interview questions:

Husband and wife communication

(Did the husband and wife discuss family planning? Who normally initiated the conversation, and who made the decisions?)

Channel of information

(How did they receive information on family planning? How would they like to receive it - from friends, relatives, health workers or mass media?)

General beliefs and attitudes

(How did they feel about contraception? Were family planning methods acceptable to them socially and culturally? Was the subject discussed openly?)

Traditional/Modern Methods

(What methods or practices did couples know and use?)

FINDINGS OF THE EXPLORATORY STUDY

Three general observations were formulated from the exploratory study's findings:

(1) Traditional methods were more difficult to discuss than modern methods. Modern methods were discussed openly in public, but informants felt traditional methods should be discussed more privately, if at all.

(2) Traditional methods were described as practices or habits, and not as methods. The term "kramaya" (method) implies a form of external technology such as taking a pill or injection, or some application etc. Traditional methods, perceived as private, were behavioral and were thus associated with terms other than "kramaya."

(3) Very often, use of traditional methods were explained by one common expression: "api paresam venava" (we are being careful). This expression was used to describe both the use of rhythm and abstinence. Probing helped to make the distinction.

Finally, it is important to note that the results of this phase of the study are purely qualitative and are not generalizable statistical estimates. They describe only the group of men and women who were participants of the study.

TRADITIONAL METHODS

The interviewers ascertained the respondents' beliefs, attitudes and practices of traditional methods of fertility control. The respondents were asked about their ideas of the postpartum amenorrheic period and lactation with respect to contraception, as well as their beliefs and attitudes about rhythm (safe period).

In addition to obtaining the respondents' beliefs, attitudes and knowledge of rhythm, abstinence and withdrawal, interviewers also attempted to find out about other contraceptive practices, such as foods and herbal medication taken by people to cause resumption of menstruation.

Breastfeeding

Most respondents did not think of breastfeeding as a contraceptive method but rather as a means of nutrition and emotional bonding for the infant. However, a common belief was that there was a relationship between breastfeeding, resumption of menses and conception.

Many women believed that it was not possible to conceive during the period of lactation, but a few women believed that even if they breastfed there was a possibility of becoming pregnant after resumption of menses.

Rhythm/Safe Period

Rhythm, also known as the safe period or calendar method, was a difficult subject to discuss, because of reticence on the part of respondents and semantic ambiguity. Some women referred to a safe period while others spoke of an unsafe period. Some calculated a safe or unsafe period from the first day of menses while others calculated it from the last day of menses (or the day following their bath).

The general impression was that a much higher proportion of couples felt satisfied with rhythm than with any modern method. An even more important observation was that rhythm was often used in combination with withdrawal.

How the safe period was calculated varied considerably. Respondents talked about the safe period by relating it to the unsafe period and vice-versa. The common method of referring to the safe period was to associate it with the onset or cessation of menstruation. Many women, particularly rural Sinhalese, believed the unsafe period was from the onset of menses until 10 to 15 days after menses. This finding corresponds to the expressed belief by some women that the womb opens during menses and gradually closes after menses.

About 10% of the respondents stated that they did not know what the safe period was. This group included some recently married couples who felt no need to know or ask about the safe period and a few who used modern methods

and did not have much interest in traditional methods. Only a few could adequately define the most fertile period, but many were able to correctly define at least part of the safe period.

Withdrawal

Withdrawal was an extremely personal topic and was best approached indirectly. The interviews also revealed that the topic of withdrawal was best approached by first discussing condoms. Couples were much more relaxed discussing withdrawal in that context. Men often felt it was a discovery of their own and thus did not consider it a method. Although the subject of withdrawal was not discussed openly among men or among women, almost all respondents knew about withdrawal and many had practiced it. Nearly half believed it was both efficient and satisfactory, and about 2 out of 3 who used it as their main method claimed that it was highly effective. The most often cited complaint against withdrawal was that it was less than fully satisfying, more so for males than females.

Abstinence

Postpartum sexual abstinence appears to be a common practice among Sri Lankan couples. There are, however, some misconceptions about abstinence, which were important in measuring its prevalance. Some respondents, for example, confused abstinence with rhythm or with abstinence during the menstruation period, and stated they abstained from sex each month. The majority of couples practiced postpartum abstinence for about 3 months, others for 6 months and a few for a much longer period. Terminal abstinence was also quite common, particularly among couples whose children had grown up or left home. Once a daughter is married, it is the cultural norm for her mother not to become pregnant again.

Other Traditional Methods

A great deal of effort was made to identify other traditional methods of fertility regulation, including abortion. To first approach the subject of abortion, women were asked if they knew of any method to cause resumption of menstruation for that is how it was described almost universally. The responses mainly consisted of eating various types of food particularly, tender pineapples and papaw and taking herbal medication. Other remedial foods mentioned included unpalatable and "heaty" type fish and shell fish, yams, meat, fish, kitul and kurakkan thalpa.[6] Drugs such as malaria tablets and aspirins were also considered remedial methods. Many couples believed that abortion was very common. Slightly more than one-sixth of the couples were willing to discuss whether they had had abortions; interestingly, about half of those couples reported that they had in fact obtained an abortion. In the qualitative survey, it was felt that no reliable information on abortion could be gathered in a large survey and hence the subject was not investigated in the main survey.

MODERN METHODS

Information was collected on attitudes toward and perceptions of modern family planning methods, how the various methods work, convenience of use and side effects. In general, nearly all men and women interviewed knew about at least one modern family planning method. Contraceptive use and attitudes toward modern methods varied according to area and cultural group.

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6 In the Sri Lankan context "heaty" implies a tendency to increase the metabolic rate in the body.

Oral Contraceptives

There was apprehension and fear about oral contraceptives among many respondents. The most pervasive belief about the pill is that it has a "heaty" effect which destroys the sperm. The majority of respondents felt that "cooling" nutritious food must be taken to counter the effect of "heat" in the body caused by the pill. The majority also reported having fear of various side effects of the pill, ranging from minor headaches to cancer.

Injectable Contraceptives

Injectable contraceptives were not widely known among the men and women interviewed. Some believed that continuous use of injections could lead to sterility.

Condoms

The most common remarks concerning condoms were that they reduced sexual pleasure and prevented "Dathu exchange" (a belief that dathu, seminal fluids is exchanged between the male and the female during sexual intercourse, to the benefit of both). There also was a general feeling that some varieties of condoms were of low quality.

IUDS

A common assessment of how the IUD worked was that it blocked the passage of sperm much the same way as a barrier method. The major reason respondents gave for not preferring use of IUDs was that they caused excessive bleeding and bodily pain. There also was some belief that pregnancy may occur while an IUD was in place, and that IUDs may get embedded in the stomach or be pushed into the chest. These reasons helped the classifications to be adopted in questions on side effects in the main survey.

Sterilization

Most women had a reasonable idea of what a tubectomy was. It was commonly described as cutting and tying tubes. The most common complaint against tubectomy was that it was more difficult to work as productively after as before an operation. Similar complaints were reported for vasectomy. There was widespread belief that nutritious food should be taken to overcome the weakness experienced following an operation.

SUMMARY

The findings based on the qualitative approach was particularly helpful in obtaining previously unsolicited information in knowledge, use and effectiveness of traditional methods. It was discovered, for example, that traditional methods were perceived by most couples in Sri Lanka as practices or habits, and not as methods. Moreover, couples perceived traditional methods as private matters and were often reluctant to discuss them openly. Ethnic, regional and ideological information on fertility behavior were collected so that the questionnaire would include the correct phrases to enable the interviewers to approach certain topics in a manner that opened the respondents to detailed discussion without confusing or misleading them.

The qualitative phase of the 1985 SLCS was instrumental in deciding the approach to be taken, the semantics, and categories to be adopted in the main survey. Local expressions, customs and beliefs were unveiled and incorporated into the questionnaire for the main survey so that the interviewers could successfully and efficiently collect in-depth information on contraceptive knowledge and behavior.

Chapter 3

KNOWLEDGE, PERCEPTIONS AND MISCONCEPTIONS ABOUT FAMILY PLANNING

INTRODUCTION

In previous surveys, knowledge of a contraceptive method was defined simply as an awareness of its existence. Using this definition, overall knowledge of any contraceptive method by married women aged 15-49 was 91% in the 1975 World Fertility Survey. In the 1982 CPS, this percentage had risen to 99%. Clearly, it is more important to measure contraceptive knowledge in somewhat greater detail. The level of knowledge of contraception can be related to the choice of a method, correct use, continuation, method failure and so forth. The 1985 SLCS attempted to ascertain several aspects of knowledge, including knowledge of a source of supply, how to use the method and how the method works (see Appendix 2).

The methods examined in detail were the pill, condoms, IUDs and injections (modern temporary methods); male and female sterilization (modern permanent methods); and rhythm, withdrawal and abstinence (traditional methods). Not all of the aspects of knowledge described above are relevant to all of the methods; for example, source of supply is not relevant to some of the traditional methods and how to use a method is not applicable to sterilization.

Respondents were not asked to choose from predetermined responses. For instance, when asked, "How does the taking of the pill prevent conception?",the respondent was allowed to explain her ideas. If the response could not be classified into one of the categories listed, it was written out verbatim.

RESULTS

AWARENESS

As expected, almost all the women interviewed in the 1985 SLCS had heard of at least one method of contraception. Table 3.1 shows the percentage of women who were aware of each method. Knowledge of female sterilization was almost universal (99%). The pill and vasectomy recorded the next highest level of awareness (92% and 90%, respectively). Slightly less but high proportions of women had heard of each of the other modern methods. Nearly three-fourths (73%) had heard of rhythm, but other traditional methods were relatively less known (withdrawal, 52%; abstinence, 48%).

DEPTH OF KNOWLEDGE

Table 3.1 also shows that general knowledge of where to obtain modern contraceptives was high (ranging from 64% for condoms to 96% for female sterilization). Most of those who had heard of a method also knew where it could be obtained, but substantially smaller proportions knew how to use a given method correctly. Approximately 40% of the respondents knew how to use the pill, condoms and injections. A smaller proportion (23%) knew procedures to ensure that the IUD was in place.

Respondents' knowledge of how contraceptives work was much lower than was simple awareness of the method. The condom scored best in this category as about 40% knew how it worked. Less than one in four (22%) knew how male sterilization worked as a contraceptive, and only 15% had similar knowledge of female sterilization. For the pill, IUD, and injectables, less than 5% correctly knew how these methods work.

Not surprisingly, the proportions differed considerally between users and never-users (Table 3.2). A much higher proportion of users than non-users knew both of a place to obtain contraceptives and how to use them. Among non-users of a method, knowledge of a source of supply was also high, although it was not as high as for users. However, a substantially lower percent of non-users than users knew how a method worked.

Knowledge of the rhythm method was considered to be knowledge of the safe periods in a woman's menstrual cycle. In the survey, respondents were asked, "What are the days you think that it is not possible to conceive?" Although the responses received were varied, most implied a safe period which is either before or after menstruation.[7] Conventionally, the most unsafe period is considered to be between 11 and 16 days after the first day of menstruation, or from 12 to 17 days before the onset of menses. The period of menses, and several days before and after menses are considered to be the most safe time period in a 28-day menstrual cycle.

These assessments of the safe and unsafe periods are based on the 28 day menstrual cycle. However, the average duration of individual women's menstrual cycles varies. Therefore, the results should be viewed merely as

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[7] Because of the many different ways women responded to the question on the safe period, it was very difficult to categorize their responses into "correct" and "incorrect" knowledge categories. Many of their responses included both safe and unsafe periods. Appendix 2 gives three categories that were considered to be correct responses.

evidence of conceptions and misconceptions the respondents have about the infertile periods in a cycle rather than conclusive evidence of correct or incorrect knowledge. A more detailed breakdown of individual responses is necessary to get a better understanding of knowledge of the safe period.

Table 3.3 shows that about a tenth of the respondents thought it was safe for a week before and after menstruation, the safest periods (category 1). A vast majority (75%) of respondents indicated a period after the start of the menstruation or end of the menstruation (i.e., categories 2 to 11 with the exception of categories 6 and 7). A smaller proportion (7%) referred to a period before the commencement or end of menstruation (categories 6 and 7).

There was a significant difference in knowledge of safe period(s) between the ever users and never users in two categories. Not unexpectedly, of the "don't know" category, 92% were never users; the proportion who reported "after 17-22 or more days from the first day of menstruation" as the safe period was significantly higher for ever users (29.7%) than never users (19.0%). Less than one percent of ever users of rhythm responded that they didn't know the safe period, compared to about 15 percent of never users of rhythm saying they didn't know the safe period.

In order to determine knowledge of how the rhythm method works, women were asked "Why do you think that a woman would not conceive during those days?". Approximately half stated that they did not know why (Table 3.4). Of those who did give a reason, about one-fifth related it to the release of an ovum. The others had some notion of the womb being open or closed during this period. Among users and non-users, a similar pattern was observed.

Respondents were also asked whether they thought it was possible to conceive during the postpartum period and while they were breastfeeding their children. It was found that almost half (48%) of women in the sample believed that a woman could not conceive before resumption of menses, while one-sixth of the women believed a woman cannot conceive during the period of lactation.

DESIRE FOR MORE INFORMATION

Respondents were asked whether they wanted to get more information on contraceptive methods, and, if so, their preferred source for such information. Approximately four out of every ten women interviewed desired more information on family planning methods (Table 3.5). Younger women, women with one or two children, and women with ten or more years of schooling showed the strongest desire for more information.

Among women desiring more information, almost one-fourth (23%) said they preferred obtaining the information from the Family Health Bureau or other governmental organizations (Table 3.6). Mass media was the next highest outlet (20%), while 18% would opt to receive the information in community group meetings.

As shown in Table 3.7, the preference was more for information on modern temporary methods than for traditional methods (44% vs. 15%). Over one-third (35%) of women desiring more information wanted more information about female sterilization.

SOURCE OF KNOWLEDGE

Table 3.8 shows that women are much more likely to hear about traditional methods such as withdrawal and rhythm from their spouses than from their doctors. The same is true for condoms. Furthermore, women are much less likely to hear about traditional methods from paramedical personnel than about modern methods. Almost two-thirds (62%) of women heard about withdrawal from their husbands, and a majority (57%) of women heard about the rhythm method from friends and relatives. Thus, traditional methods, although widely practiced, are mostly learned about from a limited number of predominantly intimate sources such as a spouse or relative. Friends and relatives are an important source of information for almost all methods, much more so than mass media sources.

SUMMARY

Reported awareness is very high for all modern methods, but relatively low for traditional methods, with the exception of rhythm. The proportion of respondents with knowledge of where to obtain the methods was high for most modern methods; however, knowledge of how to correctly use the method was much less, and few knew how most methods worked as contraceptives.

The major source of most contraceptive information has been friends or relatives, followed by paramedical personnel and then mass media. Physicians were another important source for female sterilization, and husbands were the primary source of information about withdrawal. A large proportion of respondents desired more information on contraceptives, particularly modern methods. Younger women, low parity women and more educated women expressed a greater desire for more family planning information. There was a preference to use government clinics and mass media as sources for that information.