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Community-Based Factors Affecting Contraceptive Use Patterns and Discontinuation Over the Female Reproductive Life Span : A Preliminary Anthropological Assessment

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Introduction

For approximately the past two decades, national family planning in Thailand has succeeded in reducing the rate of population increase from 3.2 percent in 1960 and 2.0 percent in 1980 to the current level of 1.6 percent. While this marked decline exists, the Thai government is still devoted to reducing the fertility rate to 1.3 percent by the end of the Sixth Five-Year National Social and Economic Development Plan (1987 - 1991). This is to be done through the use of even more finely improved family planning strategies and programs.

Since almost the beginning, Thailand's family planning services provision encountered difficulties in reducing the fertility rate, especially in Thailand's Southern and Northeastern regions, because family planning relies heavily upon the voluntary desires and decision-making processes of couples as to whether or not to use contraceptive methods.

While the National Family Planning Program (NFPP) offered various measures (e.g., health education programmes, more efficient information dissemination, increased availability of contraceptive devices) to influence couples' decisions, direct control over a couple's reproductive behavior was (and is) beyond NFPP's moral and legislative control. Hence in many communities, although family planning is an accepted social ideal, its actual practice either in terms of initiation or continuation is not always in line with this belief.

One reason for this persistent dilemma is that family planning decisions are both directly and indirectly affected by multiple contextual variables which may be social, cultural, economic and/or psychological in nature (e.g., family composition;

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community organization; household production and reproduction; personal expectations; familial status; personal; family and community norms; values and goals). Examinations of these variables and their interaction within a community context thus would, in part, provide one key for understanding the determinants of a couple's decision-making processes with regard to contraceptive discontinuation.

Generally, prior research on fertility and reproductive behaviors in Thailand and elsewhere have focused on three research lines. First, the variables determining a married woman's reproductive behaviors and decisions -- such as age, duration of marriage, education, occupation, religion, and place of residence -- have been intensively investigated. Parallel to this concentration, a second research area centers on the biomedical and psychosocial factors affecting continuation rates of various contraceptive methods, with special emphasis on the individual as the main level of analysis. Neither of these two study areas, however, have addressed themselves to systematically examining the influence of various community-based determinants (e.g., organization, norms, values, social stratification) on a couple's and especially the woman's family planning decisions as related to contraceptive discontinuation. Efforts have been made, though, to examine the interrelationship between fertility behavior (i.e., decline), family planning and changes in family and community structures (cf. Yoddumnern, 1985).

In a cross-cultural context, empirical evidence from such countries as India, Malaysia and Korea indicate that family planning behavior is shaped by the characteristics of significant social groups, i.e., *cliques*, their degree of connectedness, and the acceptance of the clique's main leader. In the Korean case for example, an individual's selection of contraceptive methods is influenced by general clique consensus and/or that of the leaders (ESCAP, 1987). One study in Thailand also demonstrates that the preference for specific contraceptive methods varies by community and region (Kamnuansilpa et al., 1988) due in part to the effect of community-based factors regulating contraceptive use decision-making. These studies form the third line of research which relates the influence of community members on an individual's reproductive behavior. However, these efforts concentrated largely on the relationship between the overt community structure and fertility behavior, while not investigating the former's influence on contraceptive discontinuation (Kanjanapan, 1985; Riley, 1972; Yoddumnern, 1981, 1985).

In light of such prior works, the present study had as its main objective to determine and analyze the inter-related factors associated with village/community

structure and organization which affect the discontinuation of contraceptive methods among women of reproductive age.

The purpose of the research is to improve future family planning service provisions by identifying key community-based factors which lead to the discontinuation of contraceptive method use. Once these factors are identified, family planning personnel at all organizational levels will be more sensitive to their existence within the community structure and their effects on individual decision-making. Thereafter, NFPP policies, programs and project, from the central to community levels, can be developed and placed on a more rational and reliable basis.

The main general finding derived from this study's qualitative analysis is that community-based factors affecting contraceptive discontinuation must be examined diachronically. Specifically, changes occur as a woman passes through three key reproductive life span stages, i.e., Stage 1 -- Pre-Childbearing; Stage 2 -- Childbearing and Childrearing; Stage 3 -- Family Size Achievement. The mechanisms involve community norms and beliefs concerning such broad but integrated areas as: childbearing patterns, infant feeding patterns, age at marriage, family planning self-management, attitudes towards family size, contraceptive method appropriateness (e.g., prevalence, convenience), infertility beliefs, personal privacy, kinship group membership, and confirmed side-effects. These come into differential play through separate types of community social networks which are activated as information on contraception is sought. The most common social network forms are intimate, effective and extended networks, but their degree of influence differs between regions.

Research Design, Methodology and Data Collection

The research project entailed an anthropological investigation carried out in the Southern (i.e., Trang province) and Northeastern (i.e., Surin province) regions of Thailand from June 1987 - April 1988. Both of these areas exhibit relatively slight reductions in the fertility rate as compared to Thailand's Northern and Central regions. Four research villages, in total, were selected for study, with two being located in each province. This selection was based on provincial and district results obtained from the Third Contraceptive Prevalence Survey as well as from monthly reports of the Thai Ministry of Public Health, and focusing on areas of particularly low contraceptive prevalence and high fertility.

The research encompassed four main data collection phases which applied different techniques and sought specific, yet complementary, types of data for each. These phases are: 1) a basic household census and mapping; 2) participant-observation with key-informant interviewing; 3) life history interviews and social network analysis; and, 4) a structured survey on household fertility and community networks. Through a combination of these four data collection phases and their methods, a qualitatively and quantitatively supported set of data was obtained which leads to an increased understanding of community influence on the selection and continuation of specific contraceptive methods. For this article, however, only the qualitative information will be presented.

Field data, both qualitative and quantitative, were collected by four research assistants, each of whom possesses a Bachelors degree in one of the social sciences, experience in conducting fieldwork investigations, and an ability to converse in the local dialect. After one month of intensive classroom and field training, the research assistants entered their respective communities (one person per village) so as to become familiar with community life and gain acceptance from community members. In total, each research assistant lived in her research village for nine months. During this time, each researcher was asked to write detailed fieldnotes for each interview conducted as well as to sort and file the data at the same time (according to the project's initial training). Supervisors visited each village on a monthly basis to give the researchers on-going support and supervision, as well as to discuss fieldnote contents and the collection of additional data. At the end of the fieldwork period, the research assistants were interviewed by project personnel to obtain their overall perceptions of and assumptions about village life as related to the research question. Research assistants thus became project key-informants (along with village informants) and their information was used to check the reliability of the data collected in terms of their experiences and insight. This allowed for a greater depth of analysis in addition to controlling for external personal factors associated with the researchers' field experiences.

Community and Family Characteristics

The Southern Context

People living in the Southern research villages are, for the most part, Buddhist of Thai nationality who speak the Southern Thai dialect. However, this region and the communities themselves are influenced by the Islamic religion and Chinese culture by

virtue of historical events and circumstances (e.g., migration, trade routes). Regarding occupations, most individuals work as hired laborers, often in local rubber plantations. Farming in terms of rice production is conducted, but rice is grown mainly for home consumption rather than for sale.

As will become evident, the social and family organization of the Southern Thai is somewhat different from their Northeastern counterparts. The two communities in Trang province can be characterized as rural and dispersed. Most families are nuclear, however post-marital residence varies according to local resource situations and negotiations made between the concerned families. A bilateral system appears to exist in this area. In times of need (i.e., loans, information, social support), for example, individuals and couples will turn to either the male or female sides of the family, depending upon the degree of social and geographic closeness. Further, within family and community contexts, male authority predominates especially in terms of decision-making (which may be caused, in part, by the influence of Islam and Chinese cultures even among the Buddhist population).

The Northeastern Context

The research villages in the Northeast are comprised mainly of Thai of Lao descent who practice the Buddhist religion and speak a Northeastern Thai dialect (mutually intelligible with the Laotian language). Other minority ethnic groups include Thai-Khmer and Thai-Chinese. The major occupations include rice farming and hired labor, the latter occurring in farming's off-season or when poor climatic conditions lead to crop failure.

The social and family organization exhibited in the two research villages in Surin province is centered around females. The settlement pattern for houses is predominantly rural and compact, rather than dispersed, and norms of matrilocal and uxorilocal residence generally characterize this area. After marriage, the couple remains with the wife's parents and assists them for a time (depending on the family's circumstances) or at least until a younger sister marries and can then, in turn, assume this responsibility. Thereafter, the original couple establishes a new household in the same compound. This type of residence pattern leads to strong familial ties with the wife's parents and family which are often activated in times of need. Evidence of overt male dominance is either absent or ambiguous, however familial authority is generally passed from father-in-law to son-in-law. Inheritance of properties, though, often follows the female line.

Major Findings

The following findings are presented according to the chronology of a woman's reproductive life span. As noted in the introduction, this period is divided into three approximate stages, that is: Stage 1 -- Pre-Childbearing; Stage 2 -- Childbearing and Childrearing; and Stage 3 -- Family Size Achievement. In part, each of these stages should not be considered mutually exclusive, since certain practices like breastfeeding may cross-cut these stages as well as the beliefs associated with them.

Stage 1. Pre-Childbearing

In this first stage, community norms exist concerning the transmission of information about family planning. Basically, knowledge and information related to family planning are socially recognized as being limited to married women only. Unmarried women who seek this type of information and/or who use birth control methods will be looked down upon, if not condemned, by community members in both provinces. The age at marriage and marital patterns of women in both study areas are quite similar. On the average, women marry at age 17 to 18 years, with girls being considered marriageable after their first menstruation at 14 to 15 years (although this low age is not considered to be too low for marriage). As a result of this norm, while women generally have heard about family planning and specific birth control methods before marriage, only a few actually know how to use them.

Most women give birth soon after marriage, without first considering the use of birth control methods. The reason for this occurrence is that in both regions the birth of the first child signifies a stable marriage and, in part, legitimates the union. Family planning, therefore, usually begins after the birth of the first child. However, not all women desire a child immediately after marriage, and they utilize specific birth control methods to avoid conception. For Southern and Northeastern women in their pre-childbearing years, contraceptive pills are selected over IUDs and injections. These latter methods are believed to dry-up the womb or uterus, thus causing infertility in such women.

Stage 2. Childbearing and Childrearing

Information Seeking Behavior

After the birth of her first child, a woman will begin to seek information and so as to select the most appropriate and socially acceptable method of birth control. Both Southern and Northeastern women show similarities in obtaining birth control information and services. In a way, their family planning information seeking is a conformed type. When they seek birth control services, they usually go in a group or at least a pair to the local health facility. These individuals are usually those who prefer a certain type of method (e.g., hormonal versus non-hormonal), or those who have similar experiences using the same method. This type of companionship is considered as a source of moral and social support.

However, there is a difference between Southern and Northeastern women in terms of channels of communication and social networks. Moreoften than not, the method (or methods) they choose is one which is widely accepted in that particular community. Through these channels, the most appropriate and socially acceptable family planning methods are introduced with the goal of socializing and re-enforcing a desired birth spacing.

In the South, information seeking behavior first begins with members of the woman's kinship group--i.e., mother, elder or younger sisters, close female cousins--who have experience in using contraceptive methods. This group corresponds to Boissevain's (1974) *intimate network*. Secondarily, information seeking is extended out to significant consociates found within peer groups and/or neighbors. This network is defined as the *effective network* in Boissevain's scheme. Through these networks, local beliefs concerning contraceptive use and discontinuation are most effectively transmitted. In addition, an extended network comprised of health personnel (largely government-trained midwives, community nurses and health workers) is also used, by virtue of their pivotal role in contraceptive obtainment and implementation, as well as their significant role in a user's decision to change methods.

On the contrary, among Northeastern women, effective and extended networks are the most influential sources of information, even greater than the intimate network. Women reported being too shy and feeling ashamed to talk about menstruation, sexual behavior and family planning with parents (especially the mother) or sisters. They felt more comfortable talking to close friends or health personnel.

Relatedly, women in these two regions share the same idea of the family planning domain. That is, this domain belongs to women, and they feel more at ease discussing contraception with other women. Most community leaders in the Northeast and Southern regions are male, who thus have little if any influence on the family planning behavior of community members. These male leaders also view family planning as being within the female domain and the responsibility of users and health workers. They would become involved in the decision-making process only if it involved their wives.

Child Care Patterns, Breastfeeding and Contraceptive Method Use

Child care patterns play a significant role in the family planning behaviors of women in both regions by regulating the type and timing of contraceptive use according to community norms and beliefs about child survival, growth and development. These norms and beliefs are transmitted through community social networks, especially those mentioned above. However, childrearing and child care patterns are different between the regions which has partially led to differential patterns of family planning behavior in both regions.

In the Southern communities, most women breast-fed their babies, but only after one to two days have elapsed since the child's birth. Southern women believe that immediately after birth, mothers do not have enough milk and until the mother's milk appears to be normal, they will feed their babies formula milk. Thereafter, mothers will continually breastfeed their children for a month (on the average) and then return to their normal activities (e.g., rubber plantation workers) after this duration. At this time, the baby will be left with either paternal or maternal grandparents or elder siblings. If neither of these are available, a *baby-sitter* will be hired. This person can either be a 9 to 13 year old individual or an elderly person. For women who work on rubber plantations, they must arrive there at around 4:00 a.m., since rubber trees are tapped in the early morning when the sap is flowing freely. The hired baby-sitters stay overnight at the woman's house and care for the baby until the woman returns the following day. This entails feeding the infant with formula milk, and breastfeeding will resume when the mother returns. For their services, young baby-sitters receive 3 baht per night (US 12 cents) while elderly baby-sitters receive 5 baht (US 20 cents). If babysitters are unavailable, mothers will take their babies to the rubber plantation with them and breastfeeding will continue during this time.

Supplementary foods (e.g., mashed banana and rice) are introduced into the babies diet when they are approximately 3 months old. By the age of 6 or 7 months, they change from formula milk to sweetened condensed milk. They believe that by this age babies are healthy enough (less susceptible to disease) to consume this type of milk. Moreover, sweetened condensed milk is more readily available, much less expensive, and cognitively closer to breastmilk than commercially-prepared milk formula substitutes. Breastfeeding will continue during this time, but only when the mother is available. Children are weaned from breastmilk when they are about one year old, though they will continue to be given sweetened condensed milk until the age of one and one-half years.

Whereas breastfeeding is usually considered one form of contraception, in this context breastfeeding and the community beliefs surrounding it are major determinants of contraceptive selection, change and discontinuation. Moreover, it is an invaluable focal point for understanding changes in contraceptive use patterns over the woman's reproductive life span in general. For Southern women who are not breastfeeding, the contraceptive pill is the most prevalent method reported in the research villages. Convenience in obtainment and an ability to control its use are major reasons cited for this preference among current users. Injections are not favored since they are viewed as too painful. Since Southern men generally do not like their wives to expose themselves to health workers (a situation cited not only by the research informants in the project areas but also Southern migrants interviewed on a post-project basis in Bangkok), IUDs are not common among the women in this study. Likewise, vasectomies are not prevalent, since birth control is seen as a woman's responsibility.

After childbirth and until the infant is fully weaned patterns of contraceptive use change. Especially, breastfeeding mothers do not utilize pills for fear that the breastmilk will dry-up or become contaminated. This belief stems from the folk concept of the relationship between *blood* and *milk* , in that anything consumed by the mother will mix with the blood in the mother's vein and be turned into milk for the baby (cf. Mougne, 1978; Vong-ek, 1987). As an alternative, they will resort either to natural family planning or the use of condoms.

In the Northeastern communities, most women fully breastfeed their children for one to one and one-half years, with mothers taking almost sole responsibility for the children during this time. Supplementary food in the form of mashed or pre-masticated rice is also given usually beginning three to four days after birth. Other foods such as vegetables which are soft and easily digestible are gradually integrated into

the infant's diet so as to familiarize the child with the adult diet and as an aid in weaning. After weaning, children are left with maternal grandparents (by virtue of the matrilocal/uxorilocal residence patterns) or the mother's female siblings. The hiring of *baby-sitters* is not reported, either in this study or from other studies of Northeastern Thai communities. If the mother does not have someone to care for the baby, she will take him/her to the field.

In sum, the duration of breastfeeding for Northeastern women is much longer than that of the women in the Southern communities. However, whereas Southern women utilize milk formula and sweetened condensed milk as supplementary foods beginning just after one month, Northeastern women more often utilize solid (though soft) foods almost immediately after birth. The care-taking patterns between the regions are similar in that close female relatives may be involved. But in the South, care-takers may also be obtained from the husband's family or through hiring non-family members.

Unlike their Southern counterparts, Northeastern Thai women in this study commonly utilize IUDs as the main means of birth control after their first child is born. But similar to Southern women who value a method's convenience, IUDs are utilized for this same reason. Once it has been inserted, women report that they do not have to worry about it, and, furthermore, the IUD can be easily removed when they decide to have another child.

After childbirth, Northeastern Thai women commence breastfeeding shortly after delivery. Breastfeeding mothers generally do not resume using any form of contraception until after six months, since it is believed to interfere with milk production and/or the woman's health. Specifically, the Southern belief that contraceptive pills will dry-up or pollute the mother's breastmilk is also held by Northeastern women. After six months, IUDs are inserted as a mechanism for birth control.

Contraceptive Method Change

Other than breastfeeding, women in both regions expressed similar reasons for changing birth control methods. These include: a) side effects, either actual or rumored; b) friends or neighbors who have heard about better methods; c) extended use of one particular method; and d) failure of the current method. In the third case, women often change methods after an extended and uninterrupted period of time. This is due to the prevailing belief that using one specific method continuously and for a long period

of time will adversely affect their health (e.g., cause infertility). For method failure, the last reason, women who were supposedly sterilized have become pregnant and were forced to undergo induced abortions. Not surprisingly, women who have been sterilized oftentimes use an additional form of contraception (e.g., injections) to ensure that they will not be impregnated.

Contraceptive Method Discontinuation

Similar to contraceptive method change, contraceptive discontinuation occurs among women in both regions who have used one method for an extended period of time or who have (or heard about) method failure and its consequences. In addition, the desire to have a child is also one logical reason.

But more significantly, the main over-arching reason for contraceptive discontinuation as reported in both regions (and for the nation in general [Kammuansilpa and Chamratrithirong,1985]) is side effects. Women who have experienced significant adverse reactions to one method (e.g., the contraceptive pill) often discontinue contraception all together so as to preserve their health. rumors of side effects are also common, but rumors which cannot be traced back to an original source/person do not determine contraceptive discontinuation. In other words, unconfirmed rumors (hearsay) are not grounds for discontinuation. If a rumor is grounded in a significant person's experience, it does to a very great extent lead to contraceptive discontinuation. The actual event is a confirmation for the decision to stop using that particular method.

The sources of side effect information and their influence on the discontinuation decision, though, differ between the Northeast and the South. In the Northeast, confirmed rumors can pass through any form of community network in reaching the woman. Moreover, the side effect need not occur among a woman's intimate, effective or extended networks only, although the information about its occurrence often reaches the woman through these networks (especially the effective network). As long as it is experienced by some community member, it is considered confirmed.

In the Southern communities however, the event is considered confirmed only when side effects are experienced by someone among the woman's kinship circle, which may cross-cut intimate and effective networks (particularly where kin group members belong to the latter network). Their rationale is that if a side effect is experienced by a

member of her kin group, a woman has a good chance of experiencing it as well. Among non-kin, the likelihood of its occurrence is small. This fear is grounded and perpetuated in the folk notion (and the kin group/community norm it sets up) concerning *right* and *wrong* substances in food and medicine. If a contraceptive method is *wrong* for one member of the kin group, it is felt that it might be wrong for other members as well. The possibility of experiencing side effects becomes greater. But as long as it is experienced by non-kin group members, this possibility is over-shadowed by the belief that the method may still be *right* for the individual.

In summary, women in the study regions prefer temporary methods of birth control although there is differential acceptance of hormonal versus non-hormonal methods. The most important factors in the selection and continuation processes are personal control (self-management), beliefs concerning breastfeeding and infertility, convenience, confirmed side effect rumors, and--in the case of the South--cultural values concerning personal privacy and kin group appropriateness. Beliefs and norms related to any of these are transmitted within the community as a whole through a woman's intimate, effective and extended networks. These, in and of themselves, overlap with those of other members where one person may be a member of two or more separate effective networks, and this person serves as the overlapping node (point of intersection and cross-communication). In the Northeast, this overlapping of networks is more pervasive than in the South. Southern women, at least in terms of side effects and contraceptive discontinuation, restrict the influence of the community to the kin group only.

Stage 3. Family Size Achievement

Community members in these two research areas share the same attitudes toward family size. That is, two children constitute the family size norm. Women who continue to have children past this size (especially in excess of three children) will be subject to community ridicule through their effective networks, in particular. They are criticized as being too traditional and conventional, as well as being less intelligent as to the circumstances of everyday life and the misfortunes a large family can incur.

These communities, though, also utilize opposing arguments when a couple wishes to have fewer than two children. A one child family is viewed as a risky situation. If the child dies, the parents will have no one to replace him/her and they will lose one potential form of old age security. A psychological argument is also

presented to the couple in that an only child will be lonely since he/she will have no playmates at home.

Childless families are totally frowned upon. Without a child, a family is not complete; only a child can make it legitimate, not the act of sexual intercourse. For women in particular, giving birth to a child changes her status in that she is considered a mature woman, rather than a person who is between immaturity and maturity (Benedict, 1952; de Young, 1955). But most significantly, childless couples are believed to have no source of old age security.

Community norms and beliefs, in these cases, control pre-family size and family size achievement levels. Methods of birth control reflect these levels in that temporary methods are socially acceptable prior to reaching a family size of two, although certain methods are preferred over others depending on the woman's reproductive life span stage and its conditions (e.g., breastfeeding versus non-breastfeeding). Permanent methods or the continued use of temporary methods before this size is attained are heavily discouraged by a woman's intimate and effective networks in both regions. In the South though, a woman's kin group is especially influential. After the attainment of the ideal family size, permanent methods of female birth control are acceptable and, in certain cases, encouraged.

Conclusion

Among women interviewed in the Northeast and Southern research villages, the community-based factors which influence family planning behavior are numerous, complex and inter-related. They become evident by focusing on separate stages of a woman's reproductive life span, and their influence changes accordingly. For women who are unmarried or newly married in either region, contraceptive knowledge may be evident, but they do not generally use any contraceptive method. For unmarried women, the use implies poor morals, whereas for newly married women it implies that the marriage is not legitimate and the couple is still *immature* . Moreover, the use of IUDs or injections, especially, may lead to infertility. After the birth of the first child, women select certain methods through the information provided by differing social networks. In the Northeast, effective and extended networks serve as the most important sources of information, and contraceptive selection depends largely on the community norms and beliefs concerning breastfeeding, child survival and development, the origin of side effect information, and infertility. Furthermore, it also rests on whether or not the couple has achieved its ideal (community perceived) family size.

This Northeastern network pattern is similar for Southern woman, except that intimate networks play a greater role in influencing contraceptive use and discontinuation, with beliefs concerning personal privacy playing a secondary role.

Family planning services, if they are to be truly effective, must take into consideration: 1) the differential acceptance of certain contraceptive methods over a woman's reproductive life span; 2) the roles of different social networks in regulating contraceptive method selection, change and discontinuation; and 3) the mechanisms by which rumors are spread and confirmed. Without these considerations, family planning providers may encourage the use of socially inappropriate methods for women, which can lead to increased contraceptive discontinuation. Moreover, if the method causes overt side effects, this occurrence likewise may not only cause the individual to cease using contraceptives but also persons within her social network. The fear of side effects may also be perpetuated through inter-personal social network information. Furthermore, by being cognizant of these three factors, family planning providers can more readily identify contraceptive use problems and locate the core persons/leaders in the community which may prove maximally effective in implementing an intervention strategy/program.

Regarding the target groups for family planning education, the results from this preliminary analysis indicate that teenagers, those who are going to get married, and newly-weds are in the greatest need of information. Through education, contraceptive method failure caused by inaccurate knowledge will be lessened, if not totally eradicated. It will also encourage these groups to consider family planning at an earlier stage than after the birth of the first child.

As for providers at the community level, regularly scheduled short-course training programs designed to increase their knowledge about family planning, birth control and community dynamics are strongly encouraged. On one level, this will increase the accuracy and efficiency of their work, as well as their own confidence in working sensitively with community members. Relatedly, they (in addition to all levels of governmental health workers) will begin to see that the quality of services, rather than the quantity, is the real indicator of program success (cf. Kamnuansilpa and Chamratrithirong, 1985). It ensures that problems are dealt with before they become out of control and thereby decrease rates of contraceptive discontinuation/drop-out.

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