NEGATIVE CONTRACEPTIVE BELIEFS: SOME EXPLANATIONS FOR DEVELOPING COUNTRIES

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This essay offers three hypotheses which explain why negative contraceptive beliefs are more likely to occur in developing countries like the Philippines and Egypt compared to developed countries. These hypotheses – sensitivity of family planning as a topic for discussion, lack of information about contraceptive methods, and the wide prevalence of pronatalist values – find support in the literature on fertility control. They also suggest that the persistence of traditional cultural values and beliefs have lessened the impact of family planning programs in many developing countries.

Anyone who has done field work in population programs has heard a *negative belief* or met someone with a strikingly incorrect idea about family planning. In certain parts of the world, misconceptions and complaints about contraceptives and their side effects are perceived to be the greatest obstacles to the adoption of family planning. These distorted perceptions involve the impact of contraceptives on marriage, health, the morals of the young, and in a more politicized context, the motives behind family planning itself.

There has been growing recognition that the use of negative beliefs in opposition to innovations can become a problem of serious proportions. An extreme case of a negative family planning belief took place, for example, in Pakistan during the late 1960s, resulting in violent demonstrations and the overthrow of a president whose pet project was family planning. The belief said that sterilization vaccinations were being administered to all school children by health workers. The panic resulted in the destruction of family planning signs, the stoning of family planning vehicles, and the burning of family planning clinics. It was later reported that the belief has been started by politico-religious leaders who wanted to overthrow the government. The attack on the president and his family planning program was justified as behavior inspired by traditional religious fervor (Rogers 1973:305).

The political situation in India during the mid-1970s presents another example of a condition that may be said to be conducive to the development and spread of negative beliefs. In response to acute political and economic problems at that time, India's ruling party (then headed by Indira Gandhi) declared a state of national emergency, and among other acts, issued a top-level policy for massive family planning campaigns. The aggressive family planning drive was characterized by a vigorous attempt to get people to adopt family planning, ranging from efforts to popularize the intrauterine device, experimentation with "negative incentive" to limit fertility, to the propagation of surgical sterilization. The government showed itself increasingly abusive through the many actions of its local leaders, and the amount of news available through open, relatively objective sources was drastically reduced. Millions of people expressed popular concern over possible entrapment into the family planning program. The degree of unrest in certain parts of the country, though actually caused by prevailing economic and political conditions, were largely attributed to the family planning campaigns. Continued fertility in general, and the continued ability to produce sperm in particular, were topics that intensely concerned many. The reports of alleged atrocities spread rapidly throughout India, doubtlessly consisting of a

mixture of fact and fiction in proportions defying precise measurement. Whatever the truth of the matter, millions of persons believed that their reproductive abilities would be jeopardized unless they took evasive action. This belief translated itself into temporarily changed lifestyles, often adopted at considerable inconvenience. For example, some people were reported to have spent from a few days to a few weeks sleeping in the field during the autumn of 1976 in order to escape the particularly forceful family planning vasectomy drive in their areas. Many limited their routine local travel, particularly by government bus, in order to minimize the risk of being "captured" for sterilization. Thus, while the Indian family planning program clearly involved coercion, the duration was brief and the range of such activities was primarily relatively close to the capital. Despite this restricted range of the actual program, the reach of the knowledge of the controversy was far greater. Millions altered their normal activities in reaction to the campaign (Toye 1977:303-316), and in this incident at least, the smoke of a belief was not far from the fire of a coercive program.

Past research on family planning communication has looked almost entirely at the "positive side" of family planning diffusion e.g., (how many, how few, are aware of or are currently using a family planning method), and rarely looked at its negative aspects (e.g., why people resist family planning, reject certain contraceptives, and so forth). The problem with contraceptive adoption seems to be a single perfect method of fertility regulation. Because many of the modern contraceptives contain complex synthetic chemicals or drugs, it is likely that side effects or complications may arise from their use. In fact, some studies have shown that actual side effects from using particular contraceptives are cited as one of the major reasons for discontinuing contraceptive use. Recent population reports[1] have carefully outlined some of the common side effects as well as the medical factors that might contraindicate use of particular contraceptives. However, as claimed by many family planning program advocates, even though some modern contraceptive methods may have rare but serious adverse reaction in occasional users, many years of use pose less threat to the health of most women than does a single addition of pregnancy and childbirth.

In many developing countries, however, the above view is still not widely accepted. Ware (1978) argues that in many Asian and African countries, the psychological and social rewards of children are so great and the perceived economic burden of childbearing to be so small that particular health risks involved in childbirth are viewed as insignificant. Hence, there is little motivation or interest in contraception. Studies have shown that many individuals who have decided upon contraception rescind their plan (even though they may already have the number of children they want) because of fear of side effects from certain contraceptives. In her study of social and psychological resistance to family planning, Sinquefield (1974) studied with low socioeconomic status women, who are black and living in rural areas of Alabama, to find out why they resist family planning. She found that many of the women who disapproved of family planning felt its use adversely affected their health, with cancer cited as a major health fear. Her study pointed out a number of other health fears mentioned by these women, among them: pain, possible prevention of future pregnancies, sickness, bleeding, general harm to health, children becoming malformed, and reduced sexual pleasure (Sinquefield 1974:129-30). In this study, Sinquefield conjectured that adopters are very likely aware of the same health fears as the resistors, but that their fears are not strong enough to block adoption. Because this study was unable to obtain comparable data on health fears of adopters, a gap still remains in understanding their contraceptive behavior.

Five years later, another study – this time of clients in Chicago (Copp 1979) – focused on factors associated with continuation of contraceptive behavior; it partially addressed the problem of fears about temporary and

long-term damage to health from contraceptive use. This study found that 18 percent of the reasons given for discontinuation referred to side effects. The important point cited by Copp (1979:197) was that, while continuers and discontinuers both experience side effects, not everyone drops out because of them. Clearly, his study suggests that there are reasons other than actual side effects that cause a client to drop out of family planning. In fact, the next most frequent reason given for dropping out was fear of damage to health (12 percent). Copp's study holds that while experience with side effects in general was associated with method discontinuation, fear of both possible long-term and short-term side effects was cited as the main reason for abandoning contraception completely (Choon-Kye 1973).

Thus far, the findings on health fears associated with family planning imply the strong possibility of "actual side effects" being misconstrued, exaggerated, or taken "out of context." The lack of understanding about the side effects and contraindications of contraceptive methods may be causing many to believe that these possibilities are automatically experienced by anyone who uses contraception. Often, such misconceptions are magnified as a result of uninformed secondary accounts. Also, sensationalism in newspapers and electronic reporting is said to be a factor. Although assertions about family planning may be true or false, this study hypothesizes that most of the patently false or exaggerated assertions may be the product of a complex proccess of social interaction carried out in a context of limited valid scientific information about contraceptive methods and how they work. In this situation, fears and misconceptions may easily develop into negative contraceptive beliefs.

It is plausible to accept that contraceptive misbeliefs could develop *in part* from lack of solid information about the methods. This lack of information may arise from little or no exposure to organized family planning communication sources. El-Kamel's Egyptian study (1981), which made use of the data from the 1980 Egyptian National Baseline Study of Family Life and Family Planning, found that low levels of knowledge characterized groups with little access to or little exposure to communication, and that low socioeconomic groups were the ones with low communication exposure (both from mass media and interpersonal sources). El-Kamel's study established, furthermore, that family planning behavior is more likely under details-of-use levels of knowledge (even if socioeconomic status or communication exposure is low) than it is under awareness levels of knowledge (even when levels of communication or socioeconomic status are high). The present study started on the logic of El-Kamel's study that lack of knowledge may be related to the prevalence of negative contraceptive beliefs.

Bertrand (1978) studied a cross-section of rural Guatemala to find out, among other things, what rumors and popular beliefs existed in regard to contraceptive methods. Many of the negative beliefs identified in her study were little different from the fears cited earlier in Sinquefield's research. Exposure to negative contraceptive beliefs was found to be significantly correlated with disapproval of family planning. Her data suggested that the greater one's exposure to negative beliefs about the pill, the less likely one is to approve of family planning. Her study showed that family planning was higher among those who did not believe that the pill is harmful to one's health. (Bertrand 1978:61-62).

After acknowledging the possible biological side effects of contraceptive methods, Rogers (1973:299) stressed that whatever the events themselves are, they must always be sensitive to sociocultural factors in their interpretation. Disadoption and discontinuance of innovations (such as family planning) may in fact have a social and behavioral explanation, just as much as it has a biological or medical explanation.

Possible Reasons Why Negative Contraceptive Beliefs Prevail in Developing Countries

Following Roger's idea, one can infer that perhaps the considerable variation in attitudes

and actual contraceptive use in many Third World countries is tied not only to a low level of knowledge of alternatives but also to other social factors that predispose individuals to adopt or not adopt family planning. This study asserts that lack of knowledge combined with various social-psychological conditions relevant to family planning lead to the prevalence and spread of negative beliefs and fears about modern contraceptive methods. Several possible hypotheses need to be examined to explain why developing countries like the Philippines and Egypt are more likely to be fertile incubators for negative contraceptive beliefs than other countries.

Hypothesis 1: Family planning is still a sensitive topic for discussion

Family planning, as an innovation in many developing countries, is still considered a taboo or emotionally "sensitive" area where the flow of information is restricted. Liu and Duff (1971), in a study done in the Philippines, found that family planning required a communication setting quite different from discussion of food production or disease prevention. While a farmer can talk openly to his friends and kin about a new rice variety, he cannot talk to them uninhibitedly about the birth control method he and his wife are using. One of the distinctive aspects of family planning ideas (when compared to agriculture or other innovations) is that they deal with beliefs that are very central to individuals. This is because family planning is perceived to be affecting sexual intercourse (Rogers 1972). The tabooness of family planning leads to a restriction of the networks through which they diffuse and consequently leads to a high degree of homophily between and among those who interact.

A study on parameters of taboo communication (Jourard 1971:229-30) established that topics relating to one's sex life (in addition to one's financial status, body, and personality) are those to be considered not disclosable. The study's findings suggested that self-disclosure[2] is most likely to occur with one's spouse, next with a same sex friend, one's same-sex parent, and least likely to occur with an other-sex friend or parent. The findings of Jourard, however, which were based on an American sample, do not seem to be fully supported by findings from developing countries even with regard to disclosure between spouses. In these countries, the sensitivity of precautions against getting pregnant while having intercourse (as a topic of discussion) is not only semi-taboo among friends and relatives, but even between husbands and wives as well.

Studies of husband-wife communication (Boonlue 1979; ECAFE 1974) have shown that a high proportion of couples in less developed countries have very little interspouse exchange on such topics as how many children are wanted or when to have them. The ECAFE report (p. 2) states that:

> The lack of communication on family planning would seem to be the consequence of at least two cultural factors: one, female modesty inculcated early in childhood makes many women reluctant to bring up such matters, and leads males to conclude that such matters are not for discussion with their wives; and two, male dominance leads some husbands to believe that the sphere of family planning is their prerogative alone, and makes wives reluctant to initiate conversation or action. Moreover, there is some evidence suggesting that when conversation does occur it tends to be one-sided: i.e., the male talking and the women listening.

To a large extent, the Egyptian family conforms to the above description. For the majority of Egyptians, the family system is still based on patriarchal authority, where the husband has privileges and responsibilities not shared by the wife. In this culture, men and women are defined as fundamentally different kinds of persons. A man should be authoritative and domineering and should prefer the company of men and not spend time with women. Men monopolize women – as women, unmarried sisters, or daughters

– and husbands have a monopoly of their wives' sexual attention (Wikan 1979). As one Egyptian expert put it, "it is due to this segregation of the sexes that an inevitable chasm exists between the respective mentalities of husbands and wives."[3] If accurate, the characterization in the literature would be consistent with the purported difficulty of husband-wife discussions of contraception in these societies.

In some Filipino households, the wife holds the purse strings and shares equal decision-making power with the husband. However, there is still inadequate discussion of issues such as family size or family planning. Among the lower classes, the assignment of rigid roles between sexes appears to be a common practice. The husband may openly socialize with friends of both sexes, but the wife may not. While middle class values are changing, a double standard in sexual conduct still exists. Rosario (1971) observed that among Filipinos in Hawaii, most families still place a high value on modesty on women. They are not expected to talk openly about matters relating to sex and not even with their own husbands. If it occurs at all, discussion of family planning ideas is confined to persons of the same sex, age, and socioeconomic background.

Taboos and behavioral restrictions associated with reproductive processes are widespread in African cultures. Sexual intercourse with menstruating women is considered taboo. The variety of terms used to describe menstruation connote "dirt," "pollution," "illness" – all derogatory meanings. Since the event carries a stigma of "impurity," strong proscriptions are placed on a menstruating woman's social activity. Behavioral norms associated with menstrual bleeding range from having women avoid rice fields, other growing plants, bathing, and cooking (World Health Organization 1981:3-16). These usages would be less critical to the present study if not for the fact that the occasional side effects caused by certain contraceptive methods – particularly the IUD–involve some bleeding. The resultant blood is not perceived as different from menstruation blood. The use of the same word impedes adoption and results in method discontinuance (Rogers 1973). In view of the degree to which observation of menstrual taboos is a nuisance, pregnancy is sought, in part to avoid the menses. Thus, pregnant women carry with them all the positive symbolic contrasts to the meanings associated with menstruation (Raum 1973:304).

It is obvious from these examples that the topic of sex and birth control still carry stigma for open discussion in public. It is this study's presumption that the sensitive nature of these issues has jeopardized the mass diffusion of correct and adequate family planning ideas in developing countries.

Hypothesis 2: There is lack of solid information about contraceptive methods

It has been shown that the concept and techniques of family planning have been widely accepted in a majority of developing countries. Yet the percentage of couples of reproductive age who are actually practicing family planning is often much smaller. One of the reasons for this gap between positive attitude and failure to contracept may be that people are not very familiar with how to use the contraceptive methods, perhaps reflecting the lack of adequate communication. Potential users may know of the methods' existence or even the names of the methods or how they look. However, knowledge of the existence of the methods, knowledge of their names, or even knowledge of their appearance is clearly not the equivalent of *how to use them*. Some people may have knowledge of and confidence in the methods, but they may not know where to get contraceptives or just how to get themselves supplied for some period of time. Effective contraception takes consistent effort on the part of the couples involved. Although the decision to use or not depends on other factors (e.g., family approval, beliefs, attitudes), practical information about the methods is still regarded as a prerequisite to continued successful use.

Many family planning programs are concerned with motivating new acceptors, and

as a result they neglect efforts at providing continued practical information. In particular, persons who may have discontinued one method because of some difficulty are not inoculated against negative false beiefs. The following anecdote dramatizes the imbalance between motivation and information in the case of one Egyptian woman:

> In a field pretest of family planning communication materials about the various contraceptive methods, one respondent was asked to identify an IUD illustrated on a poster. The woman responded: "It is a letter of the alphabet." Towards the end of the interview, the woman was asked if she had ever used a contraceptive method. She answered in Arabic, "Yes, I have an IUD."[4]

Since many Egyptian women who have had an IUD inserted have never seen it, the first principle of self-awareness (and care) from actually using contraceptives has been violated. According to local reports, women who go to clinics get medical service, but very little education about the method or its possible side effects. Such practice sets the condition for latter susceptibility to negative beliefs.

In a study of apprehensions, rumors, and misconceptions about family planning methods in India, Pandit (1970:1-3) found that the gap between publicity accorded the program and availability of quality services was the major impetus to the development of negative ideas. In her opinion, India is not keeping pace with increased demand for information. She concluded that publicity without guidance in an area in which the cultural values of the people inhibit open discussions about family planning and related matters results in even greater apprehension, more false beliefs, and misconceptions.

Negative contraceptive beliefs have been found to emerge and circulate in places where family planning is being promoted – places such as the waiting room of a family planning clinic. If waiting is protracted and the clinic personnel unfriendly, intermittent exchanges occur among the potential contraceptors. Ill-informed and anxious potential acceptors may talk about abstract contraception information that in the course of spontaneous interchange may develop into misconception. Family planning clinic personnel (even doctors and nurses) may be unreasonably biased against particular contraceptive methods and transmit these beliefs to their clients.

Other beliefs that tend to discourage modern contraceptive use seem to be the off-shoot of sociocultural factors revolving around perceptions of the contraceptives themselves. Names given to the contraceptives also structure how they are perceived and thus affect their adoption. For example, it has been reported in some countries that the pills are thought to be a curative medicine, to be taken by the woman only on the morning *after* intercourse (Rogers 1971:97). This confusion may arise because the pills are called by a name which is also used for aspirin, a plain tablet of any type, quinine, and the like. In countries such as Pakistan, India, Thailand, and Egypt, the word "sterilization" also means "castration." With the augmentation of the personal threat from the operation, it is not surprising that clients confuse the symbolic and biological apsects of the two operations. In Egypt also, the word for diaphragm is *again* (literally translated as "bike wheel"), which makes the diaphragm sound hard and frighteningly huge for a vaginal barrier.

Thus, this hypothesis relates to the interaction between partial information and personal concern. Roughly placed, between complete ignorance and complete information, there is a mid-range where interaction between anxiety and partial information motivates selection from available information of negatively colored images or perceptions that become fused with incomplete information to create negative beliefs.

Hypothesis 3: Pronatalist values and traditional beliefs are still prevalent

In most Third World countries, there is still a great pressure for early marriage and early childbearing. Families are closely knit and generally characterized by more interpersonal and social relationships built around blood ties, marriage, children, and shared residence. Much emphasis is placed on the

value of children as economic assets rather than liabilities (East-West Center 1975; Fawcett 1977). Social-psychological studies of fertility behavior have shown that disapproval of family planning has been anchored in such values as:

(a) A very large family enjoys higher social and economic status.

(b) The greater the number of children, the more fortunate or favored by God the family will be.

Under Islam, which allows a man to have up to four wives, prolific begetting of children is often regarded as a guarantee of stability for the wife (e.g., against divorce or separation). Furthermore, children are seen as conferring the status of parenthood, which in Muslim countries is a highly valued obligation under Koran Law. Children not only indicate a husband's masculinity and a wife's femininity, they are the only guarantee against the low status attributed to barrenness or impotence. Anti-family planning motives may be the result of preference for large families but also to other factors such as the importance placed on sons (Bogue 1967:21-75). Sons are highly valued because they extend the family name and help preserve the family wealth.

In many rural areas in the developing world, not only is there still a predominance of large family values, there is also still quite a number of persons who practice or perpetuate folk beliefs about contraception. Many people still cling to the belief that having children depends on God's will, and that their control is not something for the individual to decide. Often, the small number who perceive themselves as having the ability to exercise birth control still resorts to ineffective methods, such as withdrawal, abstinence, rhythm, or the use of indigenous items such as salt, flowers, seeds, and leaves.[5] (Himes 1963; Yu and Liu 1980).

There are still practitioners of folk ("witch doctor") medicine in many Third World villages whose practice is built on folk beliefs about contraception and who oppose modern family planning methods. Yu and Liu (1980:122), based on work in the Philippines, believe that folk or unlicensed contraceptive and gynecologic services are responsive to (1) extreme poverty; (2) insufficient modern health service; (3) inadequate transportation and communication facilities; (4) lack of rapport between modern "scientifically trained" health workers and the masses; and (5) the ability of folk healers to work within the cultural universe of deep-superstitions and intrafamilial sensitiveness.

The ineffectiveness of family planning in these areas may also be the result of beliefs that stem from a lack of accurate perception of how conception takes place. In many developing countries, there is a lack of understanding of the complexity of conception and the economic and psychic costs of childbearing and rearing that would permit modern contraception to seem reasonable. Sometimes, these beliefs are also perpetuated by immediate family members (such as parents, parents-in-law, and grandparents) who tend to disfavor family planning simply because they love children and thus expect close kin to work towards having many children.

Conclusion

There seems to be strong evidence that cultural values and beliefs have contributed to the underutilization and lessened the impact of family planning programs in many developing countries. It seems plausible that people who hold pronatalist attitudes, whether inspired by political, religious, economic, or other social commitments, and those whose beliefs clearly reflect misconceptions about contraceptive techniques may be said to be probable sources of negative ideas about family planning. Anti-family planning opinions anchored in beliefs and values such as the ones just described are ideas that lend themselves to misinterpretations to the extent that what persists are deviations from reality and hence are referred to as negative beliefs. It may further be said that pronatalist values and traditional beliefs about family planning could likely stem from the absence of a social context in which information about these things as well as other family goals are shared.

Notes

This paper was based largely on the author's dissertation entitled, "A Sociology of Negative Beliefs About the Contraceptive Pill in Egypt." Department of Sociology, Division of Social Science, University of Chicago, 1983.

[1]See the *Population Report* series on contraceptives published by the Population Information Program, Johns Hopkins University, Baltimore, Maryland. Refer in particular to "Oral Contraceptives in the 1980s," Series A, No. 6 and, "IUDs: An Appropriate Contraceptive for Many Women," Series B, No. 4.

[2]Jourard (1971) defined self-disclosure as the act of making oneself manifest so that others can perceive one.

[3]Aziza Hussein, former Egyptian delegate to the United Nations Commission on the Status of Women in "The Family as a Social Unit: Responsibilities of Husband and Wife," paper presented at the 8th Conference of the International Planned Parenthood Federation, Chile, April, 1967.

[4]Personal experience during field pretests conducted in one Egyptian village in connection with poster pretests for the State Information Service, Arab Republic of Egypt, during the summer of 1980.

[5]The 1983 Egyptian Follow-Up Survey found that of the 47 percent currently using a contraceptive method in Egypt, about 7 percent are still practicing some form of the ineffective folk methods. See the State Information Service and others, "Preliminary Report on the Egypt Follow-up Survey of Family Life and Family Planning," Cairo, Arab Republic of Egypt, July 25, 1982.

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