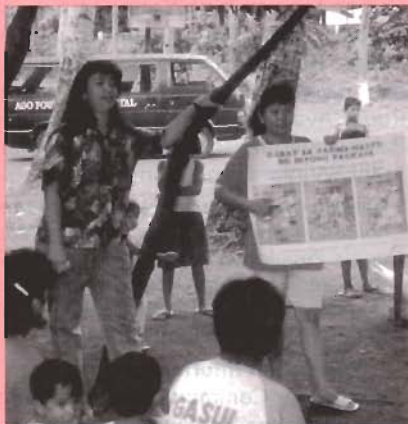
Population Reports

Informed Choice in Family Planning

Helping People Decide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The best decisions about family planning are those that people make for themselves, based on accurate information and a range of contraceptive options. People who make informed choices are better able to use family planning safely and effectively. Providers and programs have a responsibility to help people make informed family planning choices.

Decisions about childbearing and contraceptive use are most likely to meet a person's needs when they reflect individual desires and values, are based on accurate, relevant information, and are medically appropriate—that is, when they are informed choices. To make informed choices, people need to know about family planning, to have access to a range of methods, and to have support for individual choice from social policies and community norms.

Informed choice offers many benefits. People use family planning longer if they choose methods for themselves. Also, access to a range of methods makes it easier for people to choose a method they like and to switch methods when they want. People's ability to make informed choices invites a trusting partnership between clients and providers and encourages people to take more responsibility for their own health. Enabling clients to make informed choices is a key to good-quality family planning services.

An Informed Choice Strategy

The principle of informed choice refers to decisions that people can make for themselves—not to a process that family planning programs and providers carry out. Nevertheless, programs, providers, and policy-makers can do much to support people's ability to make informed family planning choices. Programs can do so best by adopting a strategy that covers five areas—government policies, communication programs, access to family planning, leadership and management, and client-provider communication.

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Supportive policies. To support people's ability to make informed family planning choices, national governments and family planning programs can set standards and guidelines for service delivery; eliminate unnecessary medical barriers and all demographic targets, incentives, and disincentives; and ensure that people can have access to the methods they prefer. National social and economic policies, too, can improve people's ability to make informed choices for themselves, as when they improve women's education and social status.

Communication programs. Communication programs can reach and inform the public about their family planning choices. In the mass media and through community social networks, communication can convey that people have a right to information about their own health and that they can make good family planning decisions for themselves, based on their own needs and desires. Messages can emphasize contraceptive methods that are available and tell where and how to find information and services. Communication programs also can encourage people to visit family planning providers for answers to their questions and concerns.

More access. The more family planning methods that are available, the more people can choose a suitable method and the better they can switch methods as their needs change. Offering a variety of methods through as many service delivery outlets as possible helps to ensure choices for everyone, including people living in rural areas, those with low incomes, those who cannot easily leave home, and those who do not want to visit clinics.

Leadership and management. Strong leadership can establish the principle of informed choice as a program goal and a measure of success. Program managers can make informed choice the organizational norm by analyzing and improving performance, providing effective supervision, training staff members, and evaluating results. Managing for informed choice requires particular attention to decisions about permanent and long-term methods—sterilization, IUDs, and implants—because these decisions are not easily reversed once they have been made.

Client-provider communication. People can make informed choices without ever seeing a family planning provider. When people visit providers, however, there is much that providers can do to ensure informed choice. Providers can ask new clients what method they prefer and usually can give them that method. They can ask continuing clients whether they would like to switch methods. They can avoid making decisions for clients or interfering with their ability to make choices. In effective counseling for informed choice, clients play an active role, asking questions, expressing concerns, and participating equally with providers.

Ensuring Informed Choice

Decisions about reproductive health and contraceptive use are among the most crucial that people of childbearing age make. With widespread endorsement of informed choice in family planning, people around the world can have better information, a wider range of choices, and more support for making appropriate decisions themselves. Ensuring informed choice in family planning should be the goal of donor agencies, governments, family planning programs, and providers everywhere.

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Why Informed Choice Matters

Choices about childbearing and contraceptive use are among the most important health decisions that many people make (162). They are most likely to meet a person's needs when they reflect individual desires and values, are based on accurate, relevant information, and are medically appropriate—that is, when they are informed choices (22).

"The process by which an individual arrives at a decision about health care" is an informed choice when it is "based upon access to, and full understanding of, all necessary information from the client's perspective," according to one definition by EngenderHealth, formerly AVSC International. "The process should result in a free and informed decision by the individual about whether or not she or he desires to obtain health services and, if so, what method or procedure she or he will choose and consent to receive" (22).

The concept of informed choice can be applied to a wide range of sexual and reproductive health decisions. This issue of **Population Reports** focuses on informed choice in family planning—including whether to seek to avoid pregnancy, whether to space and time one's childbearing, whether to use contraception, what family planning method to use, and whether and when to continue or switch methods.

The term "informed choice" refers to a decision that a person can make for herself or himself—not to a process that a family planning provider carries out. Nonetheless, policymakers, program managers, and service providers have important roles to play (see box, p. 4). Family planning programs can help people make informed choices best by adopting a strategy that covers five areas: policy, communication programs, access, leadership and management, and client-provider communication (see p. 11).

Understanding Informed Choice

In the term "informed choice," each of the two words refers to an essential aspect of family planning decision-making (182). Being informed is necessary to making a well-considered decision. But being informed is not sufficient; a person also needs choices—including access to a range of contraceptive methods, convenient sources of supply, good-quality services, and the ability to continue or discontinue using the method as desired (103).

People can make informed choices only when prevailing social policies and community and gender norms support personal decision-making regarding family planning. Such support helps people have the confidence and opportunity to make their own family planning decisions, rather than have these decisions imposed on them, whether by medical personnel, family members, community pressures, or others. Of course, people have varying levels of access to information and to choices. Educational attainment, family background, social class, and providers' attitudes are among the factors that can either aid or hinder a person's ability to make informed family planning choices.

JHU/CCP

Danielle Baron, JHU/CCP

Mrudula Amin, JHU/CCP

In Egypt (top), Senegal (middle), and India (bottom), people obtain information about family planning from family, friends, and community workers as well as from service providers. Many people make their decisions long before they seek contraception itself.

Benefits of Informed Choice

Informed choice has many benefits. The ability to make informed family planning choices increases people's control over their own lives, encourages people to take more responsibility for their own health, and invites a trusting partnership between clients and providers (306).

Continued contraceptive use. Having an informed choice encourages continued contraceptive use. People use a family planning method longer if they have chosen it for themselves (316, 318). A six-country study—in Guatemala, Hong Kong, Jordan, Kenya, Nepal, and Trinidad and Tobago—conducted between 1984 and 1987 among over 11,500 women found that continued use of a contraceptive method

Encouraging Informed Choice—What Can Be Done?

The term "informed choice" refers to a decision that people can make for themselves. Nevertheless, family planning program managers and service providers, as well as policy-makers, family planning donors, and the mass media, have important roles to play in encouraging informed choice.

Policy-makers can:

- Ensure that regulations do not restrict contraceptive options.
- Eliminate all demographic targets, incentives, and disincentives regarding family planning in national policy.
- Eliminate restrictions on mass-media advertising of contraceptive methods and family planning service locations.
- Develop national guidelines that reduce medical barriers to family planning use, and update them regularly.
- Ensure access to good-quality education for all children, so they can learn to read, write, and exercise critical thinking for informed decision-making—not just in family planning but in all aspects of life.

Family planning donors can:

- Support principles of informed choice in recipient programs.
- Assist in assuring a reliable supply of contraceptive commodities.
- Help develop indicators to measure achievement of informed choice.

Communication media can:

- Inform the public of their right to make informed choices about family planning.
- Portray providers who respect people's family planning choices.
- Present detailed, accurate, and balanced information on a variety of family planning methods, their sources, cost, effectiveness, safety, reversibility, and correct use.
- Provide technical assistance and donate air time and editorial space to mass-media campaigns about family planning choices.

Program managers can:

- Set organizational policies explicitly stating that all clients should receive the family planning method they want provided they understand the method and there are no medical reasons that rule it out.
- Ensure access to a range of family planning methods for all clients.
- Regularly evaluate service delivery procedures to ensure that clients are satisfied and able to make informed choices.
- Develop referral systems by creating links with other agencies to meet the range of clients' family planning needs.
- Ensure that printed information on correct use and the availability of other methods is provided along with contraceptives that are distributed through community-based distribution (CBD), social marketing, or other family planning sources outside clinics.

Service providers can:

- Give clients their desired family planning method unless it is medically inappropriate.
- Provide clear, unbiased information on the advantages and disadvantages of the various contraceptive methods and explain correct use of the chosen method.
- Tailor counseling and advice to each client's expressed needs and personal situation.
- Explore topics and issues that the client raises.
- Refrain from judging the client and from holding preconceived perceptions about what is best for the client.
- Respect the client's decision even if she or he chooses a less effective method than you would advise.
- Respect the client's decision to switch from one method to another, even if the client switches frequently.
- Respect the client's decision to refuse any or all services.

Help yourself, too. People considering family planning for themselves can do much to ensure that they make informed choices. They can actively seek information about their health and about family planning from the mass media and community sources. They can discuss family planning with their sex partners, family members, and friends.

If they visit a family planning provider, they can prepare questions, ask these questions, and expect to receive answers. As more and more people expect to make family planning decisions for themselves, all people will be better able to make informed family planning choices.

was strongly associated with obtaining the method that the client had in mind, as well as with a client's motivation to avoid pregnancy and the knowledge that her partner would agree with her choice of method (193). Similarly, a 1988 study in Indonesia found that 91% of women who obtained their preferred method were still using that method after one year compared with 28% of other women (317). A number of studies in the US have found that people who make their own health decisions are more likely to carry out those decisions (105, 110, 137, 168).

Offering many method choices encourages use of contraception, making it easier for people to choose a method they like and to switch methods (170). For each additional contraceptive method that is widely available in a country, the percentage of married women using contraception increases by an average of 3.3 percentage points, according to analysis of Demographic and Health Surveys (DHS) data from 44 countries (45, 351).

Many people switch contraceptive methods at least once during their reproductive years, and some use many different methods over a lifetime (165, 174, 281). When the family planning project in Matlab, Bangladesh, began to offer a full range of family planning methods, 80% of women were still using a family planning method after one year compared with 40% when only condoms and pills were offered (466).

Good-quality care. Informed choice is a key aspect of good-quality family planning. In the quality-of-care framework developed by Judith Bruce in 1990, two of the six elements that characterize good quality—choice of methods and information given to clients—are central to making informed choices (59). For family planning programs, attention to providing good care attracts clients and increases client satisfaction by offering services, supplies, information, and emotional support that clients need to meet their reproductive goals (256, 445). (See **Population Reports**, *Family Planning Programs: Improving Quality*, Series J, No. 47, Nov. 1998.)

Evolution of Informed Choice

The concept of informed choice can be traced to the late 1700s, when several prominent physicians in the US advocated demystifying medicine by giving people more access to medical information and educating patients about their conditions. The rationale, however, was that informed patients would better comply with physicians' recommendations, not that patients would be able to make informed decisions for themselves (125).

Since the advent of the family planning movement early in the 20th century, many advocates for good reproductive health have sought to expand people's access to medical information and widen their family planning choices (84). In the late 1960s the first US legislation providing government financial support for family planning programs in developing countries, through the United States Agency for International Development (USAID), strongly endorsed the voluntary practice of family planning in all such programs (433, 435).

The term informed choice itself first appeared in the family planning literature in the early 1970s (210, 233, 457), applied mainly to increasing access to family planning. In 1982 the concept of informed choice came to the forefront of international family planning policy when USAID stated that its "support for family planning service programs is based on two fundamental principles: voluntarism and informed choice" (434).

One of the first international symposiums for family planning leaders on voluntarism and choice took place in 1984, sponsored by the World Federation of Health Agencies for the Advancement of Voluntary Surgical Contraception. The focus was on the importance of voluntary choice in decisions about sterilization (24, 409).

In 1987 the Task Force on Informed Choice convened with a focus on informed choice for all family planning methods. Sponsored by USAID, the task force had representation from 17 organizations, including the United Nations Population Fund (UNFPA), the International Planned Parenthood Federation (IPPF), the World Bank, and Cooperating Agencies of USAID (411). Later, at the 1994 International Conference on Population and Development in Cairo, 179 countries agreed that informed choice in family planning is based on human rights (426). Today, most family planning programs around the world subscribe to the principle of informed choice.

This Bolivian poster says, "Family planning is the right of everyone." For decades, programs, governments, and donors have been expanding access for all who want it.

Informed choice and informed consent. The concepts of informed choice and informed consent are related but quite different in their intent. Informed consent means that a client understands the medical procedure proposed and the other options and has agreed to receive the proposed care. Informed consent alone does not constitute informed choice, however. The purpose of informed choice is to ensure that all clients decide for themselves on health care that best meets their needs.

In contrast to the evolution of informed choice, informed consent largely reflects legal opinions, beginning in 1767 in England, when a court ruled against a pair of physicians who used an experimental device on a patient without the patient's knowledge or consent (125). The term "informed consent" itself first appeared in US case law in 1957, and the medical community gradually became aware of the legal requirement to obtain the informed consent of patients to their medical treatment (231). Today, one purpose of obtaining informed consent is often to protect the health care provider from false accusations of wrongdoing, including lawsuits alleging malpractice.

In the US the concept of informed consent as it relates to family planning evolved in the late 1960s in response to policies and practices involving sterilization without consent (23). Today, in family planning programs informed consent usually is required only for sterilization, because it is a permanent method. Informed consent often involves a written statement that the client signs to verify understanding of the method, medical procedure, and risks.

Practical questions. Informed choice has become a goal in many family planning programs. Practical questions persist, however, about how best to make informed choice a reality for everyone. For example, how much does a person need to know to make an informed choice? How much can this knowledge vary from one person to the next? How much should a person know about other contraceptive methods before deciding to choose a particular method? (see p. 28.)

Questions remain for providers, too. How can providers best guide clients to make informed choices without interjecting their own preferences and values? Does the provider have responsibility for judging whether the client has made an informed choice? What is the best way for a provider respectfully to confirm that the client's understanding is accurate? These and other practical questions concern programs trying to make informed choice a reality for clients.

Figure 1

Family Planning Decision-Making

Family planning decisions reflect such external factors as (1) government policies, public information, and access to family planning, which can work either indirectly, through (2) community and household factors, or directly. Ultimately all of these factors influence (3) a person's situation and values. If a person decides to seek family planning, then (4) communication with service providers and (5) management in service delivery can further influence family planning decisions.

1

Government Policies
- Commitment to human rights
- National family planning guidelines
- Policies affecting contraceptive supply

Information
- Mass media
- Interpersonal communication
- Health literacy

Access
- Service delivery outlets
- Distance to outlet
- Characteristics of outlet
- Range of methods available
- Cost of services and methods
- Donor-supplied commodities

2

Community
- Cultural norms
- Social networks
- Religious beliefs
- Local health beliefs
- Gender roles

Household
- Attitudes towards contraception
- Relationships in family
- Marital stability
- Status within family
- Household income

3

Personal Situation & Values

Socio-Demographic
- Age
- Sex
- Educational attainment
- Marital status
- Age at marriage
- Number of children
- Ages of children
- Personal income
- Health status
- Workload
- Labor force status
- Media exposure

Life-Cycle
- Reproductive intentions
- Contraceptive experience
- Number of sexual partners
- Risk of STIs
- Frequency of intercourse
- Perceived risk of getting pregnant
- Body awareness
- Personal beliefs
- Ability to make decisions

Partner-Related
- Partner relationship
- Partner communication
- Partner's reproductive intentions

Perceptions of Family Planning
- Perceptions and expectations of providers and service delivery
- Perceptions of quality of care
- Knowledge of method characteristics

4

Client-Provider Communication
- Provider skills
- Provider age
- Sex of provider
- Provider biases
- Language
- Information received
- Similarity to provider

5

Management
- Commitment to informed choice
- Leadership
- Policies
- Confidentiality
- Waiting time
- Logistics systems
- Referral systems

DECISIONS
- to use family planning
- about which method to use
- to seek family planning
- to continue using family planning

Photos: Left– Marilyn Pialtz; Center– Danielle Baron, JHU/CCP; Right– Rick Maiman, David and Lucile Packard Foundation

Making Family Planning Decisions

The principle of informed choice focuses on the individual. Yet most people's family planning decisions also reflect a range of outside influences. These include household influences and community norms, government laws and policies, information available, and access to family planning methods and services. People often are unaware of the factors that affect their ability to make informed choices, because these factors are indirect.

Governments influence people's family planning decisions both indirectly, as when laws affect women's ability to make independent decisions, and directly, as when policies regulate access to contraceptive information, supplies, and services (67). The information and values communicated in the mass media and from person to person affect how much people know about family planning and how interested they are in it (81, 345). Access to contraception—the number of methods that are available and how easy they are to obtain—affects people's ability to use the methods they prefer (143) (see Figure 1).

While counseling has long been considered a key to ensuring informed choice, what happens before people visit a service provider may be even more important. In general, people make their family planning decisions incrementally over the course of their reproductive lives, rather than as a single choice (438).

A person's biggest family planning decisions—whether to control one's fertility and whether to use a family planning method—usually are made before the person ever seeks contraception or meets with a service provider. By the time people become family planning clients, they usually also have a particular contraceptive method in mind and already have some information—or misinformation—about it (244). For example, in each of 50 countries with DHS data, among currently married women who planned to start using family planning in the next 12 months, at least 80% said that they had a preferred method in mind. In 26 countries the percentage was over 90% (see Table 1).

In the six-country study previously mentioned (see p. 3), 75% to 100% of women had a specific method in mind when they arrived at the family planning clinic (193). Also, in Ecuador, Uganda, and Zimbabwe, over 94% of clients had a preference for a specific method before they received counseling from a provider (407). In Kenya at least 46% of new clients arrived at the clinic with a strong preference for a specific method (244). In a Nigerian clinic 55% of new clients asked for a specific method (7).

The more that policy-makers, program managers, and service providers know about how people make family planning decisions and the factors, both direct and indirect, that influence people's family planning decisions, the better they can help people make informed choices.

Table 1

Women Know What Method They Want

Percentage of Married Women Not Currently Using Contraception but Intending to in the Next 12 Months Who Know What Method They Want, 1990–1999

Region, Country, and Year	% of Women Intending To Use Family Planning Who Know What Method They Want
SUB-SAHARAN AFRICA	
Benin 1996	86
Burkina Faso 1999	95
Cameroon 1998	84
Central African Rep. 1994	88
Chad 1997	90
Comoros 1996	96
Côte d'Ivoire 1994	93
Ghana 1998	87
Guinea 1999	99
Kenya 1998	88
Madagascar 1997	85
Malawi 1992	96
Mali 1996	86
Mozambique 1997	89
Namibia 1992	95
Niger 1998	91
Nigeria 1990	84
Rwanda 1992	98
Senegal 1997	80
Tanzania 1996	91
Togo 1998	84
Uganda 1995	82
Zambia 1996	89
Zimbabwe 1994	99
ASIA & PACIFIC	
Bangladesh 1997	87
India 1999	93
Indonesia 1997	91
Nepal 1996	89
Pakistan 1991	82
Philippines 1998	96
Vietnam 1997	98
CENTRAL ASIA	
Kazakhstan 1995	96
Kyrgyz Rep. 1997	98
Uzbekistan 1996	98
LATIN AMERICA & CARIBBEAN	
Bolivia 1997	83
Brazil 1996	92
Colombia 1995	88
Dominican Rep. 1996	92
Guatemala 1999	91
Haiti 1994	96
Nicaragua 1997	95
Paraguay 1990	83
Peru 1996	82
NEAR EAST & NORTH AFRICA	
Egypt 1995	89
Eritrea 1995	97
Jordan 1997	94
Morocco 1992	100
Sudan 1990	94
Turkey 1998	85
Yemen 1997	87

DHS questions include: "Do you intend to use a method within the next 12 months?" and "When you use a method, which method would you prefer to use?"

Source: Demographic and Health Surveys

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Danielle Baron, JHU/CCP

In Senegal women come together at a community meeting to discuss their health. Community values and norms shape people's attitudes. They determine whether it is socially acceptable to use contraception and whether people can make family planning decisions for themselves.

In many countries family planning programs are part of national economic and social development efforts. Efforts to foster equity in decision-making and raise awareness about reproductive rights in the family, community, and society also promote informed choice of family planning (209). As women gain more autonomy, they are better able to claim their rights as individuals, including the right to act to protect their own reproductive health (186).

The influence of social networks. Everybody belongs to informal social networks that influence their behavior to some degree (293, 313, 354, 437). Social networks include the extended family, friends, neighbors, political groups, church groups, youth groups, and other formal and informal associations. During the course of the day, women often speak to other women about family planning and experience with contraceptive use. For many women informal communication is a primary source of family planning information (360).

The influence of social networks is crucial to informed choice. Most people seek the approval of others and modify their own behavior to please others or to meet others' expectations (52, 401, 442). Individual health behavior is influenced by how a person thinks that others view their behavior (360). In Nepal, for example, some women said that it was difficult for them to use family planning because their relatives or friends were not using it. These women were reluctant to be the first in their social group to use family planning (401).

People choose contraceptive methods that are commonly used in their community because they know that it is socially acceptable to do so, and they tend to know more about these methods (355, 442). Many women use the same family planning method that others in their social networks use (163). A 1984 study in rural Thailand found that the more widely used a method was, the more attractive it became to others in the village (121). Entire communities may encourage one type of contraceptive based on the choices of early contraceptive users, rather than individual needs (330). Even when people are aware of the side effects or failures experienced by other users of a method, sometimes they still prefer it because it is familiar (121).

While social networks exert a strong influence on most people's reproductive attitudes and behavior, family planning programs themselves influence social norms through the diffusion of new ideas about contraceptive use (81). Based on a review of studies over the previous two decades, research in 1996 found that programs have helped convert people's interest in having fewer children into a definite demand for contraception. They have done so largely by

The Individual in the Community

Social and cultural norms, gender roles, social networks, religion, and local beliefs influence people's choices (53). To a large extent, these community norms determine individual childbearing preferences and sexual and reproductive behavior. Community and culture affect a person's attitudes towards family planning, desired sex of children, preferences about family size, family pressures to have children, and whether family planning accords with customs and religious beliefs (106, 170, 448). Community norms also prescribe how much autonomy individuals have in making family planning decisions. The larger the differences in reproductive intentions within a community, the more likely that community norms support individual choices (53, 107).

Household and community influences can be so powerful that they can obscure the line between individual desires and community norms. For instance, in some cultures, many women reject contraception because bearing and raising children is the path to respect and dignity in the society (33, 75, 262). In other countries most women use contraception because having small families is the norm (275, 292). People are often unaware that such norms influence their choices.

In other cases they are particularly aware. For example, young people often decide not to seek family planning because they do not want their parents or other adults to know that they are sexually active. Many fear ridicule, disapproval, and hostile attitudes from service providers and others (219).

A person's social environment usually has more influence on family planning decisions than do the attributes of specific contraceptives. In Kenya, for example, when new clients were asked to give a single reason for their choice of a specific family planning method, most cited the attitudes of their spouse or their peers, or their religion or values (244).

making contraceptive use more accessible, common, and acceptable in many communities (143). Family planning programs are often the deciding factor for people who want to avoid pregnancy but who feel uncertain about using family planning (215, 276).

The role of social networks in the diffusion of new ideas about family planning has been recognized for several decades (345). As more and more people decide to use family planning, it has become increasingly acceptable for others to choose to do so as well (82).

Household Influences

A person's marital status, the stability of the marriage, communication with the person's partner, and status within the family influence family planning decisions (232). Some women say that contraceptive use is not an individual decision but one made by the couple or the family (107). In the Philippines 88% of women surveyed in 1994–1995 said that family planning is often a family decision (6). Many women, however, say that contraceptive use is an individual decision and that they do not involve partners and family members (100, 283, 296).

Sometimes, decisions reflect women's misperceptions of their husbands' preferences (265, 366). In Uganda, for example, 55% of wives incorrectly perceived their husbands' attitudes towards family planning, and in the Dominican Republic, 41%, according to DHS data.

For some, decisions about family planning may reflect pressures from family members—to use a particular method, for example, or not to use any method. Where women have little autonomy, their husbands, mothers-in-law, or other family members often make family planning decisions for them (384).

When partners disagree about family planning, sometimes the man's preference dominates and sometimes the woman's does (26, 33, 64, 271, 401). A study of DHS data in 18 countries found no significant patterns as to whose preference dominates when couples disagree about whether to have more children (29).

Individual Values and Personal Characteristics

People differ widely in their reproductive intentions, awareness of reproductive rights, perceived risk of becoming pregnant, attitudes about contraception, ability to make decisions, and other factors that affect family planning decisions (106, 153, 169, 187, 304, 311, 359). People also differ in their cultural and religious beliefs, and some do not use family planning at all or avoid certain methods because of their values or beliefs (100).

People's family planning preferences typically change over the course of their reproductive years, reflecting sexual experience, childbearing, contraceptive experience, as well as family structure and household economic situation (187, 241). The nature of a person's sexual relationship—whether in a long-term monogamous marriage or occasional sexual contacts, for instance—also influences the choice of contraception (160). Unmarried people who have sex infrequently or have sex with more than one partner often prefer condoms because the condom is the only method that protects against HIV/AIDS and other sexually transmitted infections (STIs), as well as against pregnancy (see box, p. 10).

People who know they have HIV may make different decisions about childbearing and family planning. A 1998 study in Côte d'Ivoire found that, among 21 women who attended an antenatal clinic and knew they were HIV positive, all said they wanted to have another child (9). A study in the US found, however, that women with HIV are less likely than uninfected women to become pregnant, more likely to get sterilized, and more likely to have an abortion (35).

Contraceptive method attributes. Most people value such method attributes as effectiveness, safety, and absence of side effects (59,172, 322). A focus-group study with women in seven countries found a strong interest everywhere in method effectiveness, protection from pregnancy for three to five years, and minimal changes in menstrual bleeding (392). Similarly, a review of research on method attributes found that women select and continue to use methods that are highly effective and have minimal side effects (190).

Still, individual preferences about contraceptive methods vary greatly. No general assumptions can be made about what attributes a particular person favors in a family planning method (90, 187, 328).

Women consider many family planning method attributes when choosing a method. They consider attributes such as whether it is permanent or reversible, whether it can be used while breastfeeding, whether it is provider- or client-controlled, how easy it is to use, whether it is male- or female-controlled, whether it must be used at each act of intercourse, whether it has added health benefits, and also what it looks, feels, or even sounds like (31, 187, 298, 322, 455).

Many people choose a particular method not because of its desirable attributes but rather to avoid the negative attributes of other methods. The choice of a particular contraceptive method may not indicate that a person likes the method but only that it seems better than other methods that the person dislikes even more (380). Because people tend to focus on possible negative consequences of specific contraceptives,

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Some women say that family planning decisions should involve their spouses and others in the household. Others prefer to make family planning decisions by themselves. People consider a wide range of factors in choosing family planning.

Choosing Dual Protection

In view of the global HIV/AIDS epidemic, it is more important than ever for people everywhere to consider dual protection—preventing both unintended pregnancies and sexually transmitted infections (STIs). Family planning providers have a responsibility to help people understand STIs, assess their own risk, and make healthy choices (414).

Assuring dual protection involves both choosing a family planning method and making decisions about one's sexual behavior at the same time. To make these decisions, a person must know whether he or she personally is at risk for STIs and also how to protect against STIs.

Assessing Risk

The provider can help clients assess their own risk for STIs by urging them to ask themselves the following questions before they choose a family planning method:

(1) Are you having sex with more than one person?

(2) Does your sex partner have sex with others or share injection needles with others?

People who answer yes to either question are at risk for STIs.

Some clients want to talk about risk and sexual behavior. Others do not. Providers need to be ready to talk comfortably and honestly about sex and risky behavior. They also need to be ready to help the client silently assess her or his own risk and make decisions without explaining. Therefore, before a client makes a final decision about a family planning method, providers should point out that any person at risk of STIs should use condoms, alone or with another contraceptive method.

Choosing Protection

As clients consider any family planning method, providers should tell them whether that method will protect them against STIs (298). Many family planning providers, however, do not. For example, in Uganda providers explained to 39% of clients whether their method protects against STIs, and in Zimbabwe 10% did (407) (see Figure 4, p. 32). In fact, presenting condoms as the family planning choice that also prevents STIs can make condoms more appealing to many people, particularly those who think their chances of getting pregnant are greater than those of getting an STI (66, 277). Indeed, some condom promotion campaigns now advertise condoms for "protection" without specifying protection from STIs or pregnancy (155, 441).

There are five ways that people can practice dual protection. Not all of them include condom use. Thus even some people who do not want to use condoms can find a way to protect themselves from STIs. People can:

(1) Use a male or female condom alone;

(2) Use a male or female condom along with another family planning method;

(3) Use a method other than condoms along with mutual monogamy;

(4) Practice only nonpenetrative sex; or

(5) Practice abstinence (203, 277, 298).

Family planning providers and communication campaigns can make people aware of all of these options.

Behavior Changing

Surveys in Africa and Latin America show that people have been changing their sexual behavior to avoid HIV/AIDS. Among never-married men and women (whether sexually active or not) who have heard of AIDS, the most commonly reported change in behavior to avoid AIDS was to stop having sex or, if not yet sexually experienced, to delay sexual initiation. Beginning to use condoms was the second most common behavior change. Among married people in every country surveyed, the most common reported change in sexual behavior was to restrict sex to the person's spouse (155).

Some family planning providers worry that advising a client who is at risk for STIs to practice dual protection may interfere with the client's ability to make an informed choice of a family planning method. In fact, however, making a family planning choice without considering STI risk and protection is not a fully informed choice. Providers, therefore, need to incorporate a discussion of sexual behavior into each client's family planning decision-making process.

With accurate information, people at risk for STIs, including HIV/AIDS, usually choose to protect themselves. For example, in a Mexican family planning clinic, among women who had information about the intrauterine device (IUD) and STIs, those at risk for STIs could rule out use of the IUD better than providers could through routine screening. After providers gave clients information on risk, the odds that a woman at risk for STIs would choose condoms almost doubled (83, 266).

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it may be more important for providers to help clients to understand the drawbacks of a method than to explain its advantages (380, 393, 455).

Many people tolerate undesired side effects and other negative attributes of contraception because they have a strong motivation to avoid unintended pregnancies (393, 455). Many women use a particular method for many years even though they are dissatisfied with it (362, 392). As one woman interviewed in Karachi, Pakistan, put it, "There is pain in these methods but at least there is no danger that the woman will conceive" (392).

The way that specific method attributes accord with individual values and health beliefs affects choices (187, 356, 361, 379). Some people choose condoms or fertility awareness-based methods because they believe that using hormonal methods will disrupt natural body rhythms that they want to maintain, while these methods will not (164). In Togo a 1998 study found that, when family planning users experienced menstrual disturbances, they interpreted them as signs that the contraceptives did not suit their bodies and thus would cause infertility. These health beliefs led many to discontinue use (188).

Some methods have attributes that make them easier for women to use clandestinely. Many women visit family planning clinics and use contraception without their husbands' knowledge (32, 257), sometimes fearing violence if their

husbands find out (46, 186). Where privacy is lacking at home, the major considerations in choosing a method for clandestine use often include how easily the method can be concealed, how to account for travel time to obtain the method, and how to hide any abnormalities in bleeding caused by contraceptive use (392).

Informed Choice Strategy

Programs can best help ensure that people can make informed family planning choices by adopting a strategy that focuses on the range of factors that influence how people make family planning decisions. A complete informed choice strategy covers five areas:

(1) Government policies. When governments establish policies that empower people to make choices for themselves and provide the services that people want, the principle of informed choice can become a reality (see pp. 11–14).

(2) Communication. Communication programs provide information crucial to family planning decision-making and encourage popular support for informed choice (see pp. 14–17).

(3) Access. Offering a range of contraceptive methods through a variety of easily accessible service locations provides more family planning choices (see pp. 17–19).

(4) Leadership and management. Program leadership and effective management help ensure services that support informed choice (see pp. 19–26).

(5) Client-provider communication. Counseling for informed choice is a partnership of two experts—the service provider as the family planning expert and the client as the expert on her or his own situation and needs (see pp. 26–33).

Policies for Informed Choice

Public polices can support informed choice of family planning. The principle of informed choice is recognized internationally and is based on human rights (426). National governments have responsibility for ensuring that the principle becomes a reality.

International Consensus for Informed Choice

Two fundamental human rights underlie informed choice: (1) the right to decide freely how many children to have and when to have them and (2) the right of access to family planning information and services. These rights have long had their basis in international consensus statements, including the Proclamation of Teheran, issued at the 1986 International Conference on Human Rights (425).

The 1994 International Conference on Population and Development (ICPD) Program of Action states that "the aim of family planning programs must be to enable couples and individuals to decide freely and responsibly the number and spacing of their children and to have the information and means to do so and to ensure informed choice and make available a full range of safe and effective methods" (426).

Governments that sign international documents of principle make a commitment to act on these principles (202). The extent of government attention to such commitments and the amount of money allocated to implementing them, however, vary considerably around the world. Informed choice advocates have urged that governments be held to their commitments, that people be encouraged to exercise their rights, and that providers respect these rights (204, 315, 320).

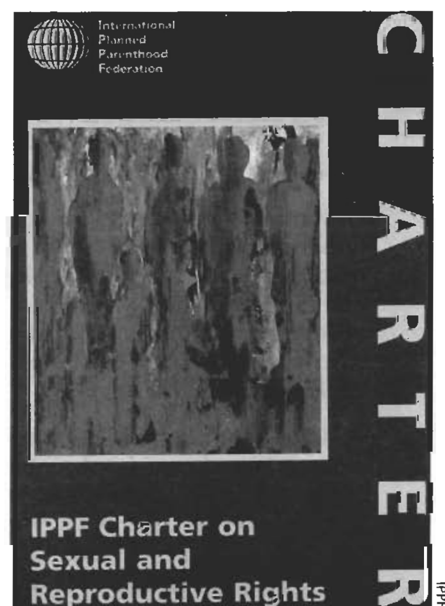
National Support for Informed Choice

National governments can help insure the right to informed choice by putting the principle into law. For example, as amended in 1974, Article 4 of Mexico's constitution states that every individual has the right to decide in a free, responsible, and informed manner the number and spacing of his or her children (376). Reflecting this principle, in the same year Mexico established the National Population Council (CONAPO), made up of eight Ministers of State, to ensure that people in every social group and in every region have access to family planning and other reproductive health services (428).

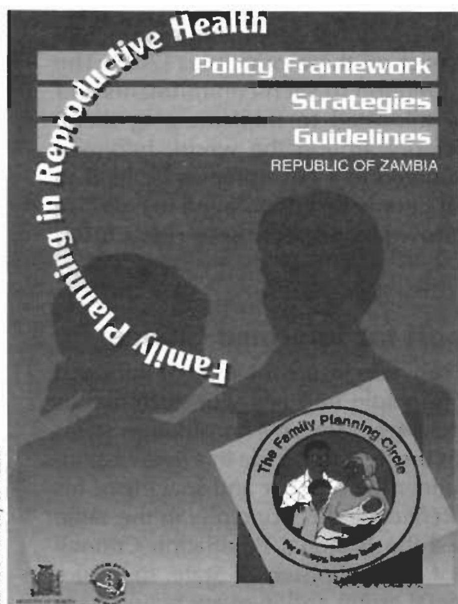
In several other countries, including Malaysia, Peru, and Zambia, laws explicitly protect informed choice (71, 131, 344). Similarly, a city law in Buenos Aires, Argentina, passed in 2000 recognizes "sexual and reproductive rights free of violence and coercion as basic human rights" and guarantees women's and men's access to contraceptive information, methods, and services (473). When governments incorporate informed choice standards into their laws, the courts can enforce them (87).

National laws and other policies for informed choice work best when they have the support of top government officials. During his career in public service, for example, former Philippine Secretary of Health Juan Flavier was an ardent supporter of people's right to make their own family planning decisions—for example, launching a national communication campaign to tell people about their family planning choices (18, 377). Under his leadership between 1992 and 1994, family planning funding quintupled, programs offered a wider variety of contraceptive methods, and the number of people using family planning increased substantially (347).

National governments play the major role in developing and enforcing standards for health services in both the public and private sectors, including guidelines for service delivery (67, 426). National family planning guidelines are most accurate when they are based on international consensus documents such as the medical eligibility criteria developed under the



The IPPF Charter recognizes the principle of informed choice. Official policies can advocate choice in family planning.



As in Zambia, countries can update their guidelines to enable more people to get their family planning method of choice.

auspices of WHO (467). As of 1998, 54 countries were in the process of updating or disseminating new service delivery guidelines, in part to eliminate barriers that unnecessarily prevent or restrict access to services (280). Many of these new guidelines state that all people, including adolescents regardless of their marital status, shall have the right and access to family planning information and services (177, 396, 412, 432).

Policies That Promote Access

Government policies often determine which contraceptive methods are available in a country and how they should be made available. Such policies include approval and registration of contraceptive products; prescription requirements; inclusion on the essential drugs list; regulations on sales, distribution, or delivery of services; restrictions on private medical practice; and policies on advertising (93, 205, 224).

Government limitations on service delivery can make it difficult for people to obtain family planning—for example, if the pill is available only by prescription, or if condoms can be sold only through pharmacies (236). Tax and import policies that increase commodity costs—for example, import tariffs, quotas, and exchange controls—often limit choice and access by deterring private and nonprofit sectors from providing contraceptives (94, 132, 133). Policies supporting decentralization or local decision-making, however, can increase access to family planning by responding better to needs specific to the community (185).

Government restrictions on advertising and promotion of prescription drugs or of family planning methods or brands usually mean that people have less family planning information (5, 236). When governments deregulate contraceptive advertising and increase broadcast airtime, people can obtain more information that helps them make family planning decisions for themselves (72).

Policies that prohibit certain methods entirely restrict choices. Japan banned oral contraceptives for family planning until 1999, when advocates for women's rights won a repeal of the ban on the basis that women needed more contraceptive choices. Some legislators argued that permitting the pill would decrease condom use and thus increase STIs including HIV/AIDS. Now, providers in Japan who prescribe the pill are required to advise women that the pill does not protect against STIs and to counsel pill users to use condoms for dual protection if they are not monogamous (302, 430).

Some countries—China and India, in particular—in effect have limited contraceptive choice through policies that promote long-term and permanent contraception over temporary methods (78, 463). Although the government of India now advocates a wider contraceptive method mix, some family planning providers still are ill equipped to offer the pill and other temporary methods (153, 199).

Eliminating Targets, Incentives, and Disincentives

Policies that establish demographic targets, incentives, and disincentives in family planning policies and programs are undesirable because they focus on achieving numerical goals instead of meeting people's health needs. Explicit policies that constrain people's family planning choices are less common now than in the past. They continue to arise occasionally, however, and remain a concern (324, 443).

Targets. Such statistics as the number of clients served, couple-years of protection, continuation rates, and fertility rates can be valuable for management, planning, and projecting program needs (350). If they serve as programmatic or performance targets or goals, however, they jeopardize the principle of informed choice and threaten the rights of clients (1, 70, 255, 446, 449, 450).

Programmatic targets originated in the 1960s and 1970s, when some countries started national family planning programs out of concern that rapid population growth threatened national well-being and that people immediately needed to start having fewer children. Today most countries have abandoned such policies in response to objections from advocates for good-quality care and women's rights, and from others (207, 331).

Governments increasingly recognize that concerns about rapid population growth can be met best not by establishing demographic targets but rather by investing in better quality family planning programs that help people meet their own reproductive goals (388). For example, in March 1998 Peru reformed its family planning policies to remove programmatic targets that in 1997 had set the goal of performing 130,000 sterilization procedures for the year (71). This target had put pressure on local health centers to perform sterilizations even among women who did not consent.

China's national family planning program, which pursued a "one-child" policy until the mid-1990s, has begun to offer more client-oriented services, and government regulations now prohibit family planning workers from imposing contraception on clients. Nevertheless, the central government has yet to fully implement the new policies, and many local practices have changed little (67, 333, 385).

Incentives and disincentives. Offering clients incentives and creating disincentives to influence people's choice of family planning methods can interfere with informed choice (207, 364), as can paying self-employed agents for recruiting clients (81). Most countries have never offered incentives or disincentives, while others have discarded them. Some programs, however, still reward clients who accept a contraceptive method (36, 261, 385). Family planning programs have offered clients money, goods, clothes, increased food rations, preference in housing, and similar inducements (261, 456, 476).

By far the most extreme population policy was in India between 1975 and 1977, when the government called a

state of emergency, suspending civil rights (398). The government initiated a mass sterilization program, offering incentives such as road paving jobs for men and in some areas coerced thousands to undergo sterilization (456). These policies created a public backlash and led to a national fear of family planning. They also contributed to electoral defeat for the party in power in 1977 (207, 398).

There is debate about what constitutes an actual incentive. Some have said that payments to clients are justified when they help overcome fear and inertia to try reversible contraceptive methods (81, 406). Others have argued that payments are acceptable when they reimburse clients for their out-of-pocket costs of obtaining contraception, including travel or meals, because such payments are considered too small to influence the client's family planning behavior (338, 404).

In Bangladesh, where family planning programs provide clean garments, subsidized food at the hospital, and the equivalent of US$3 to people who choose sterilization (226), the payment is intended to cover costs and compensate for lost work time. Whether these payments influence people's family planning decisions is unknown (225).

Disincentives usually have been designed to take effect after a couple has a specified number of children. Disincentives may include loss of maternity leave, restrictions on access to public housing, limits on schooling choices, and increased taxes (142, 340, 385). Iran's national assembly approved a law that went into effect in 1994 banning public benefits—such as paid maternity leave and social welfare subsidies to low-income women—for the birth of any child after the third (8).

Since disincentives in effect reduce a family's income, the poor feel their impact most (456). Some disincentives even focus on the "excess" children, penalizing children for the behavior of their parents (207). For example, the Indian state of Maharastra withholds subsidized food grains for the third child in an otherwise eligible family (381).

In Europe, where in a number of countries fertility has fallen below the replacement level of about two children per woman, governments have tried to encourage people to have more children by offering various incentives and disincentives (142, 251, 264, 452). In Romania from 1966 to 1989 the government imposed a tax on childless couples and limited access to contraception as pronatalist measures (97). Over the long term, however, policies that promote childbearing have had little effect (96, 314, 472).

Social and Economic Policies

Government policies for social and economic development can improve people's ability to make informed family planning choices, particularly women's. Policies that improve women's status help them to make decisions for themselves, no matter what their age, class, race, or educational level (107).

Laws governing women's autonomy can foster informed choice by allowing women to make decisions for themselves, including decisions about family planning. In some countries, however, legal codes, based on strict interpretations of customary law, require that wives always obey their husbands, fathers, or sons (86).

Education and literacy policies and programs are crucial to foster reading, writing, and problem-solving skills. Particularly when girls receive more education, these policies and programs impart new attitudes and skills that enhance informed choices in many aspects of people's lives, including family planning. Women with more education typically have more autonomy and are better able to make decisions for themselves (27, 218, 297). Also, people who can read have more access to printed information about family planning and contraceptives (128).

Policies that encourage economic opportunities for women also encourage informed family planning choices. In 1995 research in Bangladesh found that participants in a micro-credit program for women were more likely to communicate with their husbands and to have more autonomy and more decision-making authority than other women. This result held true even after researchers took into account differences between the characteristics of women who joined micro-credit programs and those who did not (12).

Donor Agencies

Most major family planning donors have official policies on informed choice that programs they fund must follow. Donor agencies with such policies include the United Nations Population Fund (UNFPA), the British Department for International Development, the United States Agency for International Development (USAID), the German Ministry of Cooperation and Development, and the European Commission (79, 95, 101, 161, 363, 433).

In October 1998 the US Congress passed an amendment, proposed by Congressman Todd Tiahrt, writing into national legislation many of the informed choice provisions that were already USAID policy. The legislation now requires that USAID formally include the policy in all agreements with organizations that assist family planning service delivery projects (433).

Lutheran World Relief

In Ecuador young people study in a rural classroom. When policies promote education and literacy, particularly among girls, they help build reading, writing, and problem-solving skills needed to make informed choices, including those about family planning.

Donor agencies, like governments, need to ensure that their program priorities do not send mixed messages about informed choice (175). Some donors prescribe that programs simultaneously address such contradictory objectives as couple-years of contraceptive protection and informed choice (16, 260). The tension between different program objectives can mean that family planning programs must decide which objective takes precedence.

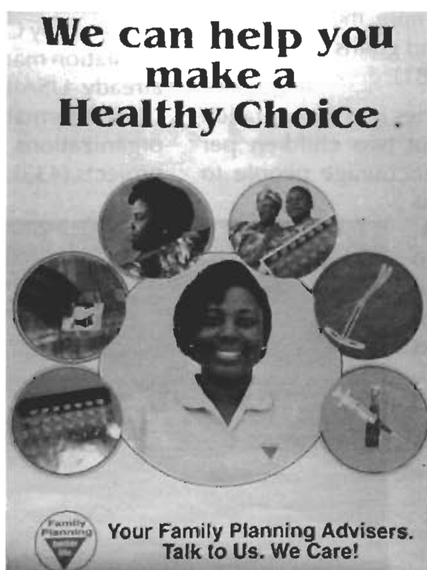
Family planning donors have long played an essential role in encouraging choice by ensuring that family planning programs have adequate supplies of contraceptive methods. Funding for donated contraceptive commodities is falling, however. In 1999 total donor support for commodities amounted to US$130.8 million, a decrease of US$12.4 million, or about 9%, from the previous year (431). Governments, donors, and programs that are committed to meeting the needs of the people will give high priority to informed choice principles and to providing the means for people to realize their choices (22).

Communication for Informed Choice

Communication plays a vital role in assuring informed choice of family planning. Effective communication empowers people to seek what is best for their own health and to exercise their right to good-quality health care (346). As noted, people make many of their biggest family planning decisions —including whether to control their fertility and whether to use a family planning method—before ever seeking contraception (see p. 7). In order to make informed choices, therefore, most people need to know a lot about family planning long before they decide to visit a health care provider.

Around the world, millions of people get their family planning information from the mass media. Sometimes it is their main source of information. In Kenya, for example, of 1,518 people surveyed in 1992, 42% said their main source of information was radio or television (252). In 49 countries with DHS data, the percentage of married women who heard or saw family planning messages on radio, television, or both in the six months before the survey ranged from 12% in Côte d'Ivoire to 92% in Jordan. Among married men surveyed in 26 countries, the percentage ranged from 24% in Mozambique to 84% in Peru.

For people who decide to become family planning clients, communication programs supplement information that family planning counselors provide. Family planning clients want information but sometimes worry that providers do not tell them all of the facts (188). While counseling is valuable, a single counseling session with a family planning provider usually cannot cover all of the information that a person needs to make an informed choice. Nor should counselors and other front-line health care providers have to bear all responsibility for seeing that clients are well informed.



As this poster from Ghana shows, communication materials can encourage people to seek information from a service provider and discuss their concerns.

Using Many Communication Channels

Using a variety of communication channels increases the number of people and the range of audiences who can receive family planning information. Increasingly, the mass media provide reproductive health messages in entertaining and memorable ways. Communication programs also build on mass media messages and extend them through community social networks and organizations.

Mass-media approaches. Many communication programs use multimedia approaches—radio, television, print, street theater, community fairs, and even the Internet—to inform people and to influence their health behavior in positive ways. Communication programs worldwide have combined radio, television, and other mass media, as well as community-based traditional media, in the Enter-Educate approach to health communication—using such popular entertainment as music and drama to convey family planning and other reproductive health messages.

Print materials provide information to help people make informed choices before, during, and after they see a health care provider. Family planning programs often distribute print materials to clients in waiting rooms or through social service organizations. Illustrations of healthy behavior can be particularly helpful to clients who have little education or cannot read (134).

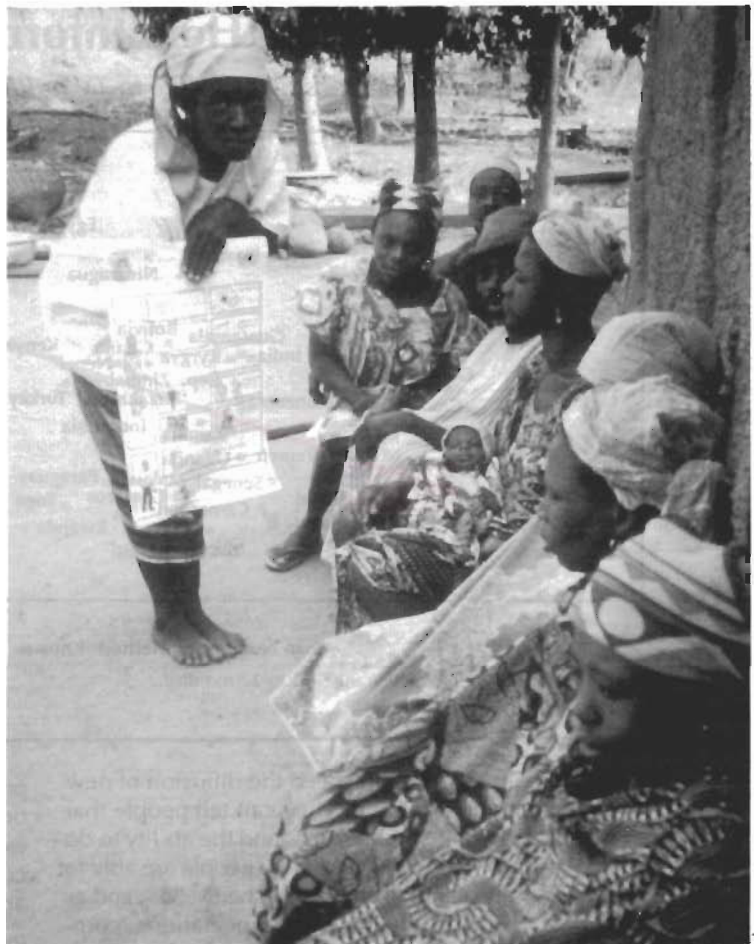
Many communication campaigns have encouraged people to make decisions for themselves and have informed them of the range of available methods. Still, few have explicitly aimed to improve informed choice. Even fewer have sought to document changes in informed choice as a result of their efforts. Most communication campaigns measure such results as the increase in clinic attendance or family planning use. They do not measure whether more people are able to make their own decisions in an informed way. To evaluate how communication campaigns contribute to promoting informed choice, informed choice should be a stated goal and be measured. Also, communication programs can monitor indicators specific to informed choice (see box, p. 23).

Community information networks. Communication programs can build on the way information flows from person to person in social networks and other community channels. For example, research in Nepal between 1997 and 1999 found that women with positive attitudes about family planning but little knowledge of it tended to seek out discussions with others they considered "local experts"—that is, long-term users of contraception in the community (55). Communication programs are a useful source of information for such opinion leaders since people who learn about family planning from the mass media often discuss it with others, who discuss it with still others in turn (56, 158, 263, 309, 471) (see p. 8).

Building coalitions of organizations can help opinion leaders and other influential people in the community know more about family planning and encourage them to help spread this information. In Uganda a project has brought together a wide range of experts representing public and private institutions in reproductive health, human rights, youth issues, journalism, law, and research to established the Coalition in Health on Informed Choice Enhancement (CHOICE) (120). The coalition works at three levels: at the community level with leaders to promote better understanding about health needs and rights; at the policy level with government ministries to focus on policies that affect access to contraceptive choices; and at the clinic and hospital levels to make administrators and health care providers more aware of informed choice.

Another program designed to help people in communities participate actively in their own family planning decisions is the Reproductive Health Awareness (RHA) approach. Developed by the Institute for Reproductive Health at Georgetown University, it emphasizes client empowerment. Through training and community education sessions, people learn to be advocates for themselves, to seek medical attention when needed, and to communicate with health care providers (62, 196, 279, 312, 460).

Family planning providers and others with experience in family planning, including clients, women's advocates, researchers, and teachers, also can reach people who want information about family planning by speaking at social group meetings and schools (103). Community groups, service organizations, nongovernmental organizations (NGOs), employers, schools, and religious groups all can be important venues for sharing family planning information (278).



Sara A. Holtz, Peace Corps

In Togo a health volunteer shows women a poster of contraceptive methods available at the local clinic. Because of such information, many people have a method in mind by the time they see a service provider.

Meeting Information Needs

To help people make informed choices, communication can stress people's right to information about personal health and their ability to make family planning decisions for themselves. Messages can point to the range of contraceptive methods available, describe the characteristics of specific methods, and tell where and how to find family planning information and services. Communication can help people get the most out of family planning counseling by discussing the need and responsibility to ask questions and obtain answers from family planning providers.

The right to information about health. Communication helps make people more aware of protecting their own reproductive health—that is, increasing health literacy (387). Health literacy refers to people's ability to obtain, interpret, and understand information needed to make appropriate and informed health decisions (341). Communication about health is more effective when it advises people of their choices and gives them something to think about than when it tells people what to do or what to think (341).

Communication programs that promote health literacy empower people to use health services effectively and sustain healthy behavior because such behavior is based on the desires of each individual. They encourage people to take active responsibility for their own health decisions, as in the Bolivian campaign "Las Manitos" (see p. 20).

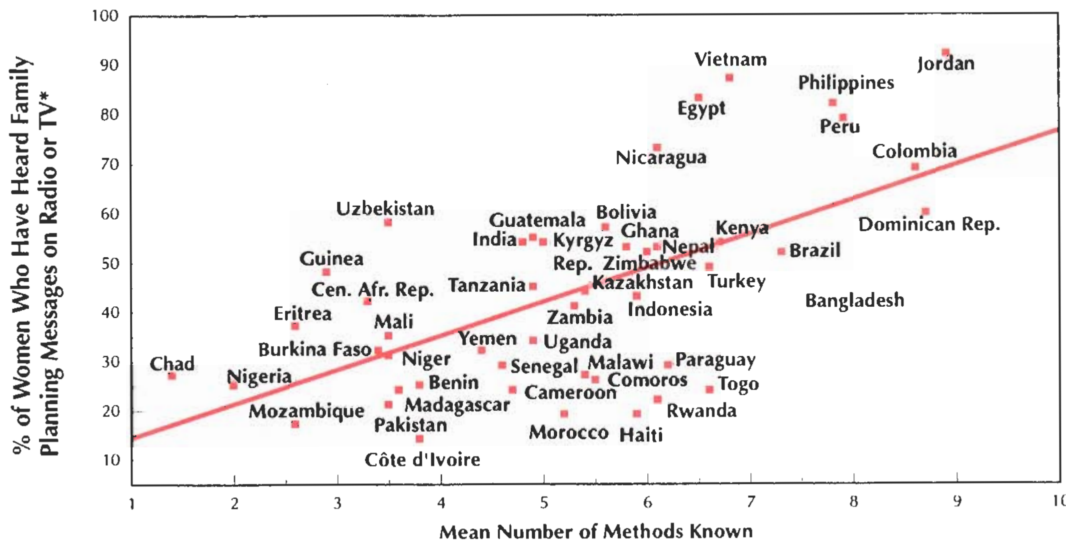
In South Africa in 1995 a national campaign, "Health Rights Are Human Rights," informed citizens about their health rights and responsibilities, including access to care, confidentiality, treatment, choice, and information. The campaign used comic strips and commercial and community radio to promote these concepts. A resource manual provided health workers, policy analysts and health planners the information they needed to integrate the respect for these rights into their everyday practice (145).

The ability to make decisions. Informed choice is a concept that is still unknown or unapplied in many places (368). Many health care providers expect to choose the appropriate treatment for their patients, and many family planning providers believe that choosing a client's contraceptive method is the provider's responsibility, not the client's right. Often family planning clients, too, do not expect to participate in medical decisions (178).

Communication programs can build people's ability and confidence in their own health care decision-making (59, 346). They can raise people's expectations of providers and encourage them to demand more from family planning services. Messages in the mass media can help create a positive image of service providers—those who care that clients' decisions are informed ones (325, 374). Such family planning communication campaign slogans as "It's your right" (Kenya, 1993), "Reproductive health is in your hands" (Bolivia, 1994), and "Ask, Consult" (Egypt, 1994) inspire people to seek information, to expect good services, and to make family planning decisions for themselves (246, 441) (see p. 20–21).

Figure 2. Mass Media Help Inform Women

Knowledge of Contraceptive Methods by Exposure to TV or Radio Messages, 1990–1999

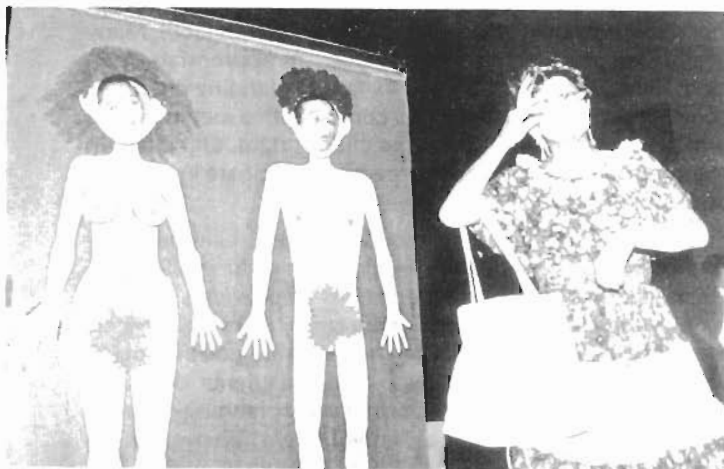


**In the last few months prior to interview (range = 1 to 12 months)*
Source: Demographic and Health Surveys

Population Reports

Communication efforts can help speed the diffusion of new ideas through communities (345). They can tell people that they have the right to plan their families and the ability to do so as they choose (367). As more and more people are able to make informed family planning choices for themselves, and as more providers respond to heightened expectations, communication can help make informed choice a social norm.

Contraceptive choices. Communication can make people aware of the range of contraceptive choices, whether they are interested in starting family planning or in switching methods. Widespread communication about contraceptive choices also is helpful because each service delivery outlet usually provides information only on the few methods that it offers, whereas people need to be aware of a range of methods and sources in order to make informed choices. Communication about contraceptive choices also helps to publicize new and lesser-known methods. Where entire communities are using the same methods due to strong social networks, communication efforts can encourage women to consider a variety of contraceptive options, not just those that are familiar (163, 330).



Patricia Poppe, JHU/CCP

In Peru street theater actors perform "Ms. Rumors," a skit developed to correct misinformation about family planning. Providing information about specific methods can lessen people's fears about contraception.

The level of awareness of a range of contraceptive methods provides a rough measure of the availability of family planning information in the country. In countries where people have more exposure to family planning messages on radio and television, people are aware of more methods (91). People's knowledge of a range of contraceptives varies widely among countries according to their mass media exposure. In Colombia, the Dominican Republic, and Jordan, women of reproductive age can name an average of almost nine methods, either spontaneously or with prompting. At the other extreme, in Chad women can name only an average of 1.4 contraceptive methods, according to **Population Reports** analysis of DHS data (see Figure 2).

People must have accurate knowledge of emergency contraception (EC)—including when to use it and where it can be obtained—since women must know in advance or soon after the fact that they can prevent pregnancy after sexual intercourse (88, 124). A 1997–1998 media campaign in six US cities significantly increased the knowledge, by at least 16 percentage points, that pregnancy is preventable after sex, and it increased knowledge by at least 9 percentage points of the term emergency contraception. In two cities knowledge that women have only 72 hours in which to begin oral EC increased by 8 percentage points (418).

Characteristics of contraceptive methods. Communication programs can provide accurate information about the characteristics of specific contraceptive methods (411). Providing method-specific messages shifts some information-giving responsibility from providers to other information sources—thus saving providers time for what they can do best face-to-face—providing good-quality counseling that helps clients think through their choices in light of their individual circumstances and helping them determine how they will use their chosen method.

Many people hold inaccurate beliefs about the characteristics of family planning methods. These often reflect concerns of people in a community. They often begin with someone's personal experience with contraceptive side effects or other problems.

Communication programs have a responsibility to help replace false beliefs without criticizing or dismissing the community members who believe incorrect information (352). Communication programs can reach service providers, too, who sometimes hold misperceptions about particular methods, often based on outdated information (54).

Between 1992 and 1994 a Peruvian street theater performance, "Ms. Rumors," portrayed a couple searching for contraception who encounter a woman spreading misinformation about family planning. Don Victor, the local pharmacist, dispels these myths and counters fears with simple explanations. Some 61,000 people saw the play. Correct knowledge about contraception increased significantly among women in the audience (439).

Where and how to find family planning. Communication can publicize family planning service delivery locations. Communication programs can tell people at any stage of the individual decision-making process where they can get information (440). They can direct people to nearby health care services and provide telephone numbers for detailed information about how to reach health care providers, as in the Egyptian campaign "Ask, Consult" (see p. 21) (240).

Print materials, which pass easily from person to person, can tell people exactly where to go for services. In Sierra Leone, for example, 78% of women who received a booklet on the pill kept the booklet and used it to tell friends and relatives how and where to get more information (59).

Ask questions and get answers. Communication programs can encourage people to ask questions. Many current and potential family planning users have questions and want answers. For instance, in a 1996 Indonesian study over 40% of family planning users wanted more information on side effects, over 26% wanted to know how contraceptives work, over 17% wanted to know how their method was affecting their menstrual cycle, and over 18% wanted to know what to do if problems occurred (206).

Researchers in Nepal found that, when both clients and providers had listened to a distance education radio program about client-provider communication, the number of active client behaviors, such as asking questions in a counseling session, increased significantly, from an average of 2.9 to 3.3, and the average number of facilitative provider behaviors, such as encouraging questions, increased from 7.8 to 8.3 (54, 223). Such communication programs for communities improve both client and provider communication skills, which reinforce each other in the clinic.

Continuing clients, especially, need continued encouragement to seek information that addresses their concerns. In Indonesia a 1996 study found that implant users knew that their implants must be removed in five years, but they did not know why. The concept of a decreasing amount of hormone was unclear to them. Because they lacked accurate information, many thought that the five-year rule might be arbitrary, with little consequence to their health. As a result the belief emerged that the implant rods themselves prevented pregnancy and could be maintained after the five-year limit as long as the woman had no medical symptoms (194). For more effective contraceptive use, communication programs need to encourage clients to seek out accurate information from reliable sources.

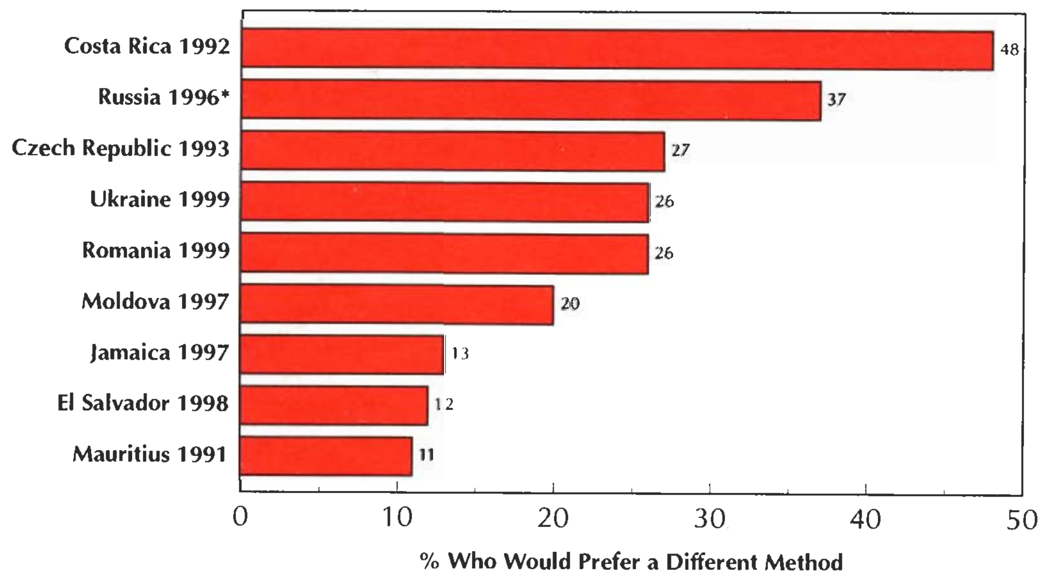
Improving Access

Offering widespread access to as many contraceptive methods as possible is key to helping people make informed family planning choices. As more methods become available, and as access to these methods increases, more people can find the methods they want.

Many people are using a family planning method other than the one that they prefer. For example, among nine countries with comparable reproductive health survey data, the percentage of women who said that they would rather be using a different method ranged from 11% in Mauritius to 48% in Costa Rica (see Figure 3). Most often, the reasons were that the preferred method was too expensive, too difficult to obtain, or not available at all. Other reasons included medical ineligibility and family disapproval. Other studies report similar findings (19, 393, 407).

More Methods Mean More Choices

As more contraceptive methods become available, more people can find a method that suits them—initially, and later if they want to switch methods (170). Today, a larger variety of contraceptives exists than ever before. Nonetheless, to ensure more choice for more people, new contraceptive methods are needed (130, 159, 187, 287), and several are in development (48).



The range of contraceptive choices vary widely. Among developing regions, Latin America provides the widest range of methods, and Africa, the narrowest (357). Although virtually every country provides at least a few methods, in many countries people have little or no access to certain methods.

Among 88 developing countries studied in 1999, the average percentage of couples who had convenient access to condoms was 79%, to oral contraceptives 76%, to IUDs 61%, to female sterilization 43%, and to male sterilization 29%. This analysis gives equal weight to each country regardless of population size. The same study found that couples in 50 countries have little or no access to vasectomy; in 29, to female sterilization; in 14, to IUDs; in 5, to oral contraceptives; and in 2, to condoms (357). Reflecting differences in availability of specific contraceptives, countries have widely different contraceptive method mixes (151). At the national level, a country's method mix can sugggest whether people can make informed choices (41).

The option to switch methods is central to continued use of family planning (90). Having a range of methods helps people switch methods when their needs change, rather than use one that has become inappropriate or unsatisfactory or else to discontinue use of contraception altogether. Offering a range of methods also helps ensure that at least some methods will always be available, even where shortages occur because the supply chain is erratic (60).

To expand contraceptive choices, family planning programs can offer fertility awareness-based methods along with supply methods (189). Service providers should be able to explain fertility awareness methods to their clients or else know where to refer clients for training in these methods. Studies are underway in five countries to examine access to fertility awareness-based methods (160, 273).

How many methods? Few programs have the resources to offer the entire range of family planning methods. How wide a range of methods must a program offer to ensure choice? WHO guidelines on contraceptive method mix do not mention specific methods that programs should offer. They state that "programs should provide a variety of types of methods to meet the different needs of different individuals and couples" (465). Other experts advise programs to offer:

- Contraception options both for men and for women,
- Temporary methods and permanent methods,
- Hormonal methods and nonhormonal methods,
- Supply methods and fertility awareness-based methods,
- Provider-controlled methods and user-controlled methods,
- Contraceptive options for breastfeeding women, including the Lactational Amenorrhea Method (LAM), and
- Emergency contraception (178).

Because most family planning programs in developing countries depend on donated commodities, they often can offer only the methods that donors provide. Reductions in donor contributions typically reduce people's access to family planning. Increased donor support is crucial to ensuring informed choice (see p. 13–14). In addition, changes in donors and the methods that donors supply, as well as supply cycles and poor coordination, often cause temporary outages in contraceptive supplies (429).

Offering More Sources

Broadening the types of service delivery can provide more choices, especially for people whom conventional programs have difficulty serving (327). These include people with low incomes, those in rural areas, women who cannot leave their homes, and others who want their contraceptive use to remain private (335, 395). In addition, with more service delivery outlets, people who want a particular contraceptive—for example, a specific brand of condom or pill formulation—can more easily find it.

Many people base their choice of family planning on how accessible a method is—particularly if visiting a clinic requires long travel (160). A nearby source can even make the difference between using contraception and not using it at all. In Morocco, for example, a survey of women who in 1992 had not intended to use contraception found that by 1995 those who lived close to a hospital, clinic, doctor, or pharmacy were more likely to be using family planning than those who lived farther away. While such other factors as social and economic differences or changes in reproductive intentions could explain the difference, the researchers concluded that proximity to a source of supply was the most likely reason (276).

Programs can offer methods through community-based distribution, social marketing, and private providers, as well as through family planning clinics and hospitals. In CBD programs fieldworkers visit each household in the community or use community organizations and institutions to offer contraceptives (16, 323).

Although CBD can be expensive to sustain (217), it expands family planning choices by bringing contraceptive methods to people rather than requiring people to visit clinics or pharmacies

Rick Maiman, Courtesy of the David and Lucile Packard Foundation

In Mexico youth counselors travel by bicycle-carts through urban areas, providing contraceptives and information. Offering more sources of family planning can provide people with more choices.

(197). CBD can be especially helpful if CBD agents are trained to give contraceptive injections safely, thereby increasing the method choices they can offer (337). CBD agents, however, cannot be effective counselors if they prefer to offer only methods that they can provide immediately and so stress supply methods over methods involving referral (244).

Contraceptive social marketing—the promotion and sale of family planning methods at subsidized prices—can improve access by making contraceptives better known, more affordable, and widely available through shops, pharmacies, and other retail outlets. Social marketing programs typically offer condoms, pills, and spermicides and have proved particularly successful at marketing condoms for STI prevention (108, 135, 375).

Population Services International

A pharmacist in Cambodia demonstrates how to use a condom correctly. When pharmacists and other private providers are trained to offer detailed information on correct use of family planning methods, they can help their customers use their chosen method more effectively.

For the most part, social marketing programs are designed to promote specific contraceptives, not to ensure information about and access to a range of methods. For this reason some have argued that social marketing programs—no matter how well-intentioned—inevitably bias people's family planning choices (335). Increasingly, social marketing programs are training pharmacists, shopkeepers, community health workers, and others who sell social marketing brands to provide clients with more information about family planning choices (11, 126). Social marketing programs can encourage retailers to discuss the range of methods with customers and to offer information about safety and instructions for proper contraceptive use (17, 148, 334).

Pharmacies, private-practice physicians, and other private-sector providers are a growing source of family planning supplies and services (238, 270). In developing countries the commercial sector serves 20% of women who use modern contraceptive methods (390). In some countries people say that private family planning services offer better quality than public services, and people are increasingly able and willing to pay the full price of services (47, 390, 417).

Managing for Informed Choice

For family planning programs, improving the management of service delivery can improve clients' ability to make informed choices. Managing for informed choice requires commitment by leadership and an environment designed to give clients what they want. Ensuring that clients are able to make informed choices requires attention to such key managerial areas as analyzing and improving performance, providing effective supervision, training staff members, and evaluating results.

Management should take special care that clients who choose permanent or long-term methods—sterilization, IUDs, and implants—are making informed decisions. Also, managing for informed choice is particularly important in low-resource settings, where staff members may be few, contraceptives in short supply, and informational material scarce.

Program Leadership

Strong leadership can establish a program environment that facilitates informed choice (386). If top managers set an example of ensuring informed choice, other staff will follow. Mentioning informed choice in the program's mission statement and in official policy guidelines can help staff members and clients become aware that the program is committed to the principle of informed choice and to clients' rights (209, 220).

For example, the International Planned Parenthood Federation (IPPF) policy on informed choice states that all IPPF-affiliated Family Planning Associations (FPAs) shall facilitate access to a broad range of sexual and reproductive health services, including counseling, for all individuals who request them. Also, FPAs are to ensure that services are provided in a noncoercive manner, that the provision of services is not linked to financial incentives, and that no service is conditioned on the acceptance of another service. All FPAs must agree to this policy as a responsibility of membership in IPPF (192).

In programs where the concept of informed choice is new, leadership can make sure that all staff members at all levels of the organization understand it (106). Program leaders can ensure that no program targets, incentives, or disincentives for contraceptive use remain (see p. 12). Even though targets, incentives, and disincentives are rarely official national policy, and donors generally do not support family planning programs that maintain targets, a target-oriented work culture sometimes remains (253, 398). Programs can establish clients' ability to make informed choices as a major indicator of program success, alongside or even instead of such conventional indicators as growth in the number of new clients (25, 212) (see p. 23).

Program leadership can support the principle that all clients should receive the contraceptive method they want if it is medically appropriate, in keeping with up-to-date national medical guidelines. Leaders can help remove the barriers

(Continued on page 22)

Promoting Informed Choi

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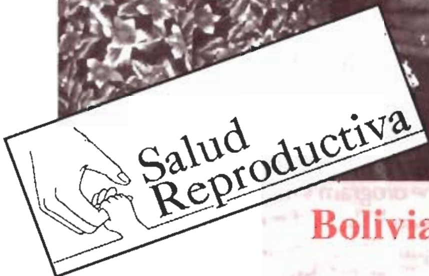


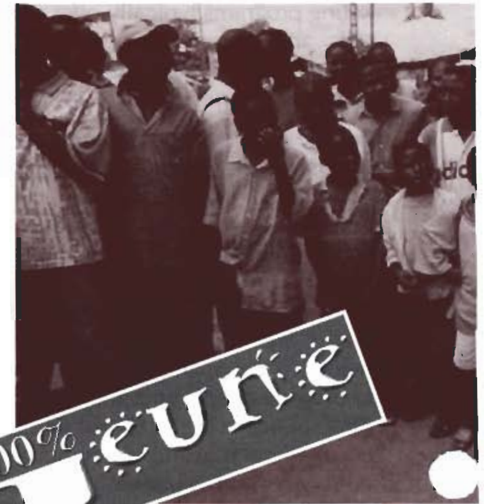
Bolivia—*Las Manitos*

In 1994 the Bolivian Ministry of Health, with assistance from the Johns Hopkins University Center for Communication Programs (JHU/CCP), launched the mass media campaign *Las Manitos* ("Little Hands"), declaring that "Reproductive health is in your hands." The campaign featured the "little hands" logo in television and radio spots, clinic videos, posters, and other print materials. A primary message of the campaign was that, by becoming more aware of their contraceptive options, couples could take responsibility to make reproductive health decisions that best suited their own needs (441).

One television spot featured a young couple strolling through a playground surrounded by children. The wife says, "Juan and I want to have children, but not as many as my friend Elena. We don't know what to do." A nurse appears on the screen and explains to the viewers, "The solution is in your hands. Reproductive health centers can help you decide as a couple the number of children you want to have and when. ... For this, there are methods that are safe and reliable. You decide." A narrator concludes, "Reproductive health is in your hands. Ask for information in a health center where you see 'the hands.'"

The campaign showed that mass media messages inform the public about contraceptive methods and encourage them to take responsibility for their own health decisions. Evaluation found that 66% of radio and television audiences surveyed spontaneously remembered at least one campaign message such as, "Obtain family planning information at health centers" and "Reproductive health is in your hands."

Among women ages 18 to 35 who saw or heard campaign messages often, awareness of modern contraceptive methods increased from 83% to 95%. The percentage of women who approved of family planning also increased, from 86% to 91% (441). Among people who sought reproductive health services during the campaign, 28% reported that they were motivated by the television and radio spots, and 39% reported "self" as the source of motivation (441).



Cameroon–

From 1996 to 1997 Cameroon's social marketing program, Le Programme de Marketing Social au Cameroun (PMSC), an affiliate of Population Services International (PSI), carried out the adolescent reproductive health program *Horizon Jeunes* in the town of Edéa. The campaign used youth-oriented promotional events, peer education and counseling, radio talk shows, brochures, and other media formats to promote safer sex, inform youth about condoms and oral contraceptives, promote visits to health centers, advocate contraceptive use, and encourage young people to talk about responsible sexual behavior (444).

Evaluation found that the program's strategy of using combined mass media approaches was able to inform specific groups about contraceptive options, encourage discussion with health workers and others in the community, and help youth to make healthy decisions about sex. In 13 months knowledge of contraceptive methods among young women and men

ce Through Communication

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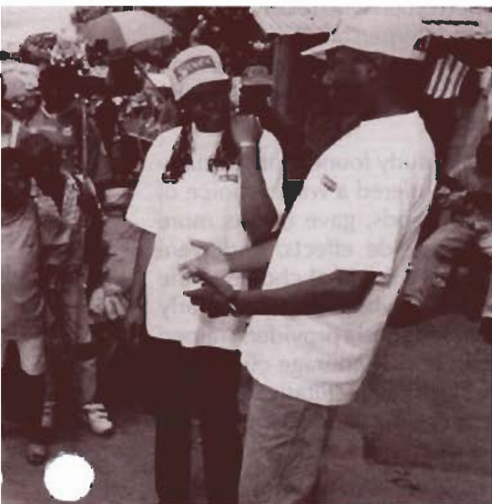


PSI

–*Horizon Jeunes*

increased substantially in Edéa compared with little increase in a comparison site where there had been no campaign. Among men in Edéa, knowledge of condoms increased from 65% to 71%, knowledge of the pill increased from 13% to 39%, and knowledge of the IUD and of injection increased from 4% to 27%. Among women in Edéa, knowledge of condoms increased from 39% to 74%, knowledge of the pill from 23% to 60%, and knowledge of the IUD and of injectables from 7% to 35% (444).

The percentage of youth who discussed contraceptives and sexuality increased, from 84% before the campaign to 90% among men and from 86% to 92% among women. Specifically, discussion with health workers increased from 17% to 28% among men and from 15% to 38% among women. The proportion of young women who said that they were responsible for their own protection from STIs and unintended pregnancies increased from 74% to 84% (444).

INTERMARKETS: EGYPT

Egypt—"Ask, Consult"

In 1994 Egypt's Ministry of Health and Population, with support from USAID and the assistance of JHU/CCP, The Futures Group International, and Pathfinder International, established the "Ask, Consult" project within the private health sector. The project was developed to train private-sector physicians and pharmacists in the latest developments in contraceptive technology and counseling techniques and to supply them with family planning informational materials for clients, since few had had family planning training in the last five years. Some 95% of pharmacists had never been trained in family planning (389).

The project illustrates how a private-sector communication project can improve access to family planning. It informed people about additional service locations, increased choices by marketing new contraceptive methods, and encouraged people to ask questions and seek information from providers. A communication campaign was launched to promote participating providers as sources of reliable contraceptive information and to associate them with the "Ask, Consult" logo, or "mark of confidence."

The campaign included television and radio spots, billboards, point-of-sale promotional items, clinic signage, public relations, and client leaflets encouraging people to ask the newly trained pharmacists and physicians about contraceptive options. Advertisements also informed people about specific contraceptive methods, including the newly available progestin-only oral contraceptives.

Within about five years, more than 7,000 pharmacists and 3,000 private physicians were trained, given up-to-date contraceptive information and educational materials, and stocked with a broad range of family planning methods, including the new progestin-only pills. Moreover, 89% of television-viewing women remembered seeing a family planning message on TV within the previous six months. Of these, 42% said they spoke to their husbands about family planning as a result of the message, 37% said they wanted more information, and over half visited a clinic for family planning advice (227). The "Ask, Consult" logo helped to start conversations about family planning between clients and providers, evaluation found (389). Also, sales of progestin-only pills increased from 63,000 packets in 1997 to over 600,000 in 2000 (200).

that prevent certain groups, such as young people, from using some family planning services or methods (see p. 26).

When guidelines promoting informed choice are clear and understandable, and they are widely followed, they can increase people's contraceptive options. For example, after Tanzania developed new family planning service delivery guidelines in 1994 and carried out a year-long dissemination process that included training, service providers began to offer injectables to all women. Previously, many providers had seen injectables as a dangerous drug that should be prescribed only by doctors and reserved for women with many children (451).

In Kenya, after a similar process of guidelines dissemination in 2000, the percentage of providers recommending dual protection—using condoms alone or together with another method to protect against STIs as well as against pregnancy —increased from 9% to 23%. The percentage of new clients who were denied family planning services because they were not menstruating declined from 47% to 29% (237).

Improving Performance

Management approaches that identify the source of problems with quality of care and develop appropriate solutions can improve clients' ability to make informed choices. One such approach is Performance Improvement (PI)—a process for identifying the most important root cause of gaps between desired performance and actual performance (274). Another is the systems approach, in which family planning managers examine the role of each part of service delivery and how it influences clients' ability to make informed choices (256, 278).

In addition, training providers in interpersonal communication skills is important to informed choice because these trained providers are better able to involve clients in health decision-making (358). In Egypt women who received counseling from providers trained in interpersonal communication knew more about how to use their methods and expressed more satisfaction with services than those seen by other providers (2).

Also, in Ghana a study found that specially trained providers offered a wider choice of contraceptive methods, gave clients more information about side effects, and were more likely to leave the final choice to the client than providers who were not similarly trained (195). In Indonesia providers trained to foster rapport and encourage client participation doubled their facilitative communication in counseling, and clients asked twice as many questions (249).

Continuing support and reinforcement. Trained providers need continuing support and reinforcement from managers and supervisors to keep their skills fresh (222, 249, 250). Recognizing providers who help ensure informed choice—for example, by giving promotions, new titles, and more authority—complements training (220, 386). In addition, programs can maintain provider performance through on-site training, distance education, and self-assessment (58, 343, 412, 462). Management also can make communication job aids such as wall charts, cue cards, flip charts, and checklists accessible for providers to improve their performance and help clients make informed choices (234).

In an Indonesian study self-assessment and peer review helped to maintain providers' performance. Four months after the training, the percentage of providers' remarks that fostered rapport and client participation declined from 29% to 27% among those who did not have any reinforcement. By comparison, among providers who assessed one of their own counseling sessions each week, the percentage of such utterances increased from 28% to 33%. In the group that also participated in weekly peer review meetings to discuss their own performance, such utterances increased from 28% to 37% (249).

Do you know your family planning choices?

COMBINED ORAL CONTRACEPTIVES

DMPA INJECTABLE CONTRACEPTIVE

NORPLANT® IMPLANTS

PROGESTIN-ONLY ORAL CONTRACEPTIVES

CONDOMS

IUD (Intrauterine Device)

VAGINAL METHODS

FEMALE STERILIZATION

VASECTOMY

Some Methods Are Not Advised for Certain Health Conditions

FERTILITY AWARENESS-BASED METHODS

LAM (Lactational Amenorrhea Method)

Your family planning provider can answer your questions. Please ask!

This wall chart is available in English, French, and Spanish. Health care providers can request it by checking the box in the order form on the back of this issue.

Monitoring and Evaluation

How well programs help people to make informed choices provides a key measure of program success (286). Managers can gauge a program's ability to ensure informed choice by monitoring a variety of indicators (see box at right).

Among the techniques that can apply to evaluating informed choice are using "mystery clients" or other observers in clinics, conducting exit interviews with providers and clients, and analyzing transcripts or videotapes of counseling sessions (256). Evaluation also can examine the number of methods available, the policies governing eligibility for receiving methods, fee structures, use of communication aids such as wall charts, and such service statistics as contraceptive method mix and referrals (286, 319, 407).

Using the HARI Index, developed by the Population Council, also can help programs determine how well they help clients choose a method appropriate to their needs and situation, use it effectively, manage side effects, and switch to another method when desired. HARI, which stands for "Helping Individuals Achieve their Reproductive Intentions," measures how well a person is able to achieve fertility goals without suffering reproductive health morbidities in the process (211, 214, 239).

Another new evaluation approach for use in service delivery provides a checklist for informed choice and informed choice training modules that were developed by EngenderHealth (259). Also, the MEASURE Evaluation project has developed a tool called the Quick Investigation of Quality, which includes some components for monitoring and evaluation of informed choice (407).

Evaluating Informed Choice

EVALUATION QUESTIONS CAN HELP MEASURE WHETHER FAMILY PLANNING CLIENTS ARE ABLE TO MAKE INFORMED CHOICES:

To evaluate *any family planning program:*

1. Does government policy specifically mention the right to a free and informed choice to plan one's family?
2. Does government policy avoid setting numerical targets and avoid offering incentives or disincentives that impede informed choice?
3. Does the family planning agency specify that informed choice is a key goal?
4. Has the family planning agency eliminated all unnecessary medical barriers and arbitrary restrictions on who can be served?
5. Are program procedures for ensuring informed choice the same for men and women?
6. Is informed choice covered in training?
7. How many contraceptive methods are approved for distribution?
8. How many methods are available at the service site?
9. For how many methods are clients referred to other programs?
10. Do clients receive their method of choice?
11. Are clients satisfied with the method they received?

Adapted from: CEDPA 1996 (72) and Hardon 1997 (179)

To evaluate *client-provider communication:*

1. Does the client participate actively in the discussion and selection of the method?
2. Does the provider encourage the client to ask questions?
3. Does the client ask questions and receive courteous and complete answers?
4. Does the client receive his/her method of choice?
5. Can the client explain why he or she chose the method?
6. Does the provider ask about the client's reproductive intentions?
7. Is the provider responsive to the client's questions?
8. Does the provider ask the client which method she or he would prefer?
9. Does the provider give accurate, detailed information on the method chosen?
10. Does the provider tell the client whether the chosen method protects against STIs including HIV/AIDS?
11. Does the provider tailor key information to the particular needs of the specific client?
12. Does the provider give instructions on when to return?
13. Are all methods that the program provides available at the time of the client's visit?

Adapted from: MEASURE Evaluation 1999 (286)

IN ADDITION TO THE QUESTIONS ABOVE, THE FOLLOWING QUESTIONS CAN BE ANSWERED:

To evaluate *community-based distribution (CBD):*

1. How many nonclinical methods are available from CBD workers?
2. Do CBD workers refer clients for methods that are not available in the CBD program?
3. Do CBD workers put any restrictions on methods beyond those stipulated by program policy?

Adapted from: The EVALUATION Project 1993 (122)

To evaluate *retail outlets such as pharmacies:*

1. How many contraceptive methods are available?
2. Does the retailer refer customers for methods that are available only elsewhere?
3. Does the customer receive adequate information about how to use the product?
4. Does the retailer think that the information he or she has about the product is adequate?

Adapted from: The EVALUATION Project 1993 (122)

To evaluate *communication programs:*

1. Do people know they have the right to make informed choices for themselves?
2. Do people know about family planning methods?
3. How many methods do people know about?
4. Which methods do people know about?
5. Do people accurately understand these methods, including how to use them?
6. Do people know where to get these methods?
7. Do people know where to get family planning information?
8. Are people planning to consult a family planning provider for more information or guidance?
9. Do people speak to family or community members about family planning?

Adapted from: Bertrand and Kincaid 1996 (40)

Helping Women in Special Situations

Postpartum and postabortion women deserve extra care to ensure that they can make and carry out informed family planning choices.

Postpartum Family Planning

A woman's presence in a medical setting during pregnancy presents an opportunity for health care providers to inform her about the range of family planning options. Many women have difficulty making major decisions during labor or immediately postpartum because of the pressure of time and the pain and stress of childbirth (49, 50). Therefore, prenatal counseling for postpartum contraception is needed, especially when women consider permanent or provider-dependent methods (235). Particularly if a woman considers sterilization, she should make her decision before giving birth, since the chances that a woman will regret her decision are higher among women who decide at delivery than among women who have made the decision earlier (129, 468).

Providers should never ask women to make contraceptive choices while they are in labor or sedated. Stress, pain, and sedatives may hamper their ability to make decisions. Nor should a husband's consent serve as a substitute for the woman's while she is sedated. Women are more likely to regret a decision made by the husband alone than when the decision is made by the wife alone or by the couple (414).

Contrary to the principle of informed choice, some providers equate postpartum contraception with IUD insertion or sterilization only (349). Thus they do not offer other methods. Some providers feel obliged to convince postpartum women who already have many children to have a sterilization procedure or IUD insertion (212). For their part, women who have already consented to sterilization may be under the impression that, because they have delivered, they must now go through with postpartum sterilization. For this reason, after the delivery it is wise to review the client's decision with her to find out if she has changed her mind (184).

Susheela Engelbrecht, JHPIEGO

A Ghanaian health provider gives prenatal care to a pregnant client. Offering women contraceptive counseling before they go into labor helps foster informed decisions about postpartum family planning.

Postabortion Family Planning

Many women have induced abortions because they were unable to make informed choices about family planning. If a woman does not have the opportunity to make an informed choice *after* an induced abortion, then the health care system has neglected her twice (269).

Women receiving postabortion care should be informed that another pregnancy can occur almost immediately. They need to consider if they want contraception. They should be able to choose from a range of methods. Provided the woman has no other medical condition that rules out a particular method, all contraceptive methods can be used safely after abortion, and most methods can be started immediately after treatment for complications (182) (see *Family Planning following Postabortion Treatment,* supplement to **Population Reports,** Series L, No. 10, Sept. 1997). Protection is needed immediately because fertility returns soon after abortion. Often, referral systems are needed to make it easy for postabortion women to get the contraception they want (305, 469).

Providers who work with postabortion clients can help women best if they avoid expressing disapproval or taking actions that limit a woman's contraceptive choices (365). Similarly, provision of care should not be contingent on a woman accepting contraception in general or using a particular contraceptive method (469).

Clients may say after an abortion that they will never have sex again, and they may refuse contraceptives (305). Nevertheless, providers can give information on a variety of methods and how to obtain them. They also can give these women supplies of condoms, pills, or oral emergency contraception, which the women can take home and use if needed (269).

Permanent and Provider-Dependent Methods

Family planning programs have a particular responsibility to ensure that all clients are making informed decisions when they choose sterilization, which is permanent, or IUDs and implants, which women cannot discontinue using without a provider's assistance. Counseling for informed choice is the role of individual providers, but program management can establish systems that help ensure that these clients are making informed choices for themselves.

Sterilization. Women and men under age 30 and with few children should be carefully counseled when they consider sterilization. People in these groups are most likely to regret their decision (76, 115, 180, 208, 415). Some medical guidelines state that sterilization is rarely appropriate for adolescents and should be considered only in exceptional, medically indicated circumstances (51, 123). Nevertheless, having received information in counseling, a young client has the right to know that there is no medical reason to deny sterilization or any other method based on age alone (136).

Once a client has received sufficient counseling and has made an informed choice of sterilization, it is not necessary to require a waiting period before the procedure. If clients are currently using another form of contraception, however, they should be offered the choice to take time to think about their decision (61, 414, 464, 468). In particular, women may need time to think if they decide they want sterilization at delivery or immediately afterwards (49, 50, 235) (see box, previous page). Clients should understand that they can change their minds at any time before the procedure.

Many programs require that each client sign an informed consent form to document the sterilization decision and to indicate that the client understands the permanence of the procedure (61). Regular audits of informed consent forms help ensure that all clients who received permanent methods consented to them. Satisfying informed consent requirements is not a guarantee that a client is making an informed choice, however (see p. 5).

In order to make an informed choice about sterilization, a client must understand the following five points before the procedure:

- Temporary contraceptive methods are available;
- Sterilization is a surgical procedure;
- Certain risks are associated with the procedure, as well as benefits, and both should be understood;
- If successful, the procedure is permanent and will prevent the client from ever having any more children; and
- The client can decide against having the procedure without losing the right to medical, health, or other services or benefits (61).

IUDs and implants. When a woman is using an IUD or implants, programs should be prepared to offer advice and care over many years so that she can switch methods or discontinue use entirely whenever she chooses. Managers can establish a system that makes implant and IUD removal services continuously available. They can develop strategies for reminding clients when implants and IUDs should be removed and, if the client wishes, replaced (419). Managers can check client records to make sure they contain the dates that IUDs and implants were provided (194).

Liz Gilbert, Courtesy of the David and Lucile Packard Foundation

In the Philippines a health worker uses pictures to explain to a client how her contraceptive method works. Managers can ensure that all staff have the materials they need to help clients make informed choices for themselves.

Providers should accommodate any client who wants to stop using a method—whatever the client's reasons or ability to pay. Managers can ensure that staff members are trained in IUD and implant removal. Some implant users have reported difficulties getting health care providers to remove implants (372, 477). Some providers tell clients that, because implants are costly, they will not remove them for minor side effects; some providers have refused women who requested implant removal because of amenorrhea (282, 477).

In addition, women sometimes face obstacles when they want their IUDs and implants removed because removal requires time and aseptic conditions. Clinic staff are not always able to remove implants at the time a woman comes in, and some providers do not feel confident of their ability to remove implants (397, 477). Some clients do not want to continue using IUDs and implants but do not know that they can be removed before five years (477), while others think that removal would cost more than they can afford (228).

Any client who reports problems with her IUD or implants should be explicitly offered removal as an option and asked outright if that is what she wants. Providers should heed her wishes (183).

Choice in Low-Resource Settings

Managing for informed choice does not need to be costly if it focuses on anticipating problems. In fact, ensuring that clients can make informed family planning choices can conserve resources. For example, studies have shown that informing clients seeking implants about their common bleeding side effects leads some women to choose another method. These clients avoid a method that they would later regret, while the program saves the cost of the implants and the time of inserting and subsequently removing them (80, 140, 310).

To save time, providers can first identify a client's needs and then focus counseling on just those methods that the client wants to know about (103). Longer counseling sessions do not always lead to more information exchange. For example, a 1999 study in Peru found that, although providers covered

more information during counseling sessions that lasted at least 9 minutes compared with shorter sessions, the amount of information exchanged improved only slightly more during counseling sessions that lasted longer, from 15 to 45 minutes (268).

In every program, but especially in low-resource settings, effective logistics management can save money, ensure that contraceptive supplies are continuously available, and help deliver services efficiently. Managing the commodity supply chain effectively also helps avoid wasting contraceptives through spoilage (127). When supplies are scarce, programs can find more cost-effective ways to offer them—for example, charging small user fees. Such charges also help ensure informed choice, since most people will agree to pay something for a method they have chosen themselves (103, 417).

Better Client-Provider Communication

Good communication between clients and family planning providers during counseling is key to informed choice. When counseling is a partnership, in which clients and providers communicate openly, share information, express emotion, and ask and answer questions freely, clients are more satisfied, understand and recall information better, use contraception more effectively, and live healthier lives (104, 109, 173).

The process of making informed family planning choices begins long before people visit a provider, of course, and many people make informed choices without face-to-face communication with a provider. When clients do seek services, however, there is substantial evidence on what clients and providers can do together to ensure that family planning decisions are based on the principle of informed choice.

Counseling for informed choice, like good counseling in general, should be thought of as a partnership of two experts —the provider as the medical expert and the client as the expert on her or his own situation and needs (391, 432). Clients can play an active role in the counseling session (248), while providers can understand and address clients' concerns, desires, and needs—engaging in a genuine dialog (299, 436).

Improving Counseling

Family planning clients and providers both have responsibilities to ensure that the counseling process reflects the principle of informed choice and leads to family planning decisions that clients make for themselves. A number of obstacles often stand in the way of good client-provider communication. These include unnecessary medical barriers and other restrictions that providers place on services, providers' own preferences about contraception and biases toward or against certain methods, both providers' and clients' discomfort with discussing sexuality, the differences in status and knowledge between providers and clients, and gender bias. Finding ways to surmount these obstacles helps foster informed choice.

Avoiding unnecessary medical barriers. Sometimes programs and providers inappropriately prevent clients from receiving the contraceptive method of their choice by adhering to scientifically unjustifiable policies or practices, based at least in part on a medical rationale (39, 382). Outdated contraindications sometimes remain in a program's official guidelines or providers' informal screening routine (39).

These unnecessary medical barriers can inhibit informed choice even where official policies try to ensure that medically eligible clients get the methods they want (383, 467). In a study in five African countries, for example, providers imposed twice as many eligibility criteria as the current national family planning guidelines required (288).

Also, in Kenya a study in 1999 estimated that 78% of nonmenstruating women were sent away without services to wait for their next menses to confirm they were not pregnant—an unnecessary restriction for most hormonal methods (399). Many clients who are turned away never get their contraceptive method of choice or any other method, as they are unable to return to the clinic (396).

JHU/CCP

Health workers in Nepal participate in an interactive radio education training program about family planning counseling. Training providers, along with offering continued support, increases their technical knowledge about family planning and improves client-provider communication.

Avoiding provider bias. The principle of informed choice means that providers avoid bias and, instead, respect client's preferences over their own—even if a client chooses a less effective method, uses a method only sporadically, switches frequently from one method to another, or refuses any or all services (139). Nevertheless, many providers think that they should make family

This list of suggested questions may be detached and displayed or copied and distributed to clients.

The Choice Is Yours.

Please Ask!

You are welcome to ask about your family planning choices.

If you have a method in mind, please tell your family planning provider which one.

If not, you and your provider can discuss your needs and find a method that suits you.

Here are some types of questions you can ask:

You can ask about your family planning method choices. For example,

- "The family planning method I want is ________. Can you tell me about it?"
- "What other methods do you offer?"

You can ask about your concerns or worries. For example,

- "Are there any health problems or side effects with this method? What are they?"
- "Will I be able to have children later on?"
- "Will it protect me from diseases like AIDS?"

You can ask about how to use the method. For example,

- "Do I have to touch my insides to use it?"
- "Do I need to do something with the method before having sex or during sex?"
- "Does my partner have to agree to use it?"

You can ask about something you think you know but are not sure of. For example,

- "I can change methods if I am unhappy with this one, right?"
- "No one will know that I am using it, is that so?"

You can ask about a word or phrase that you did not understand. For example,

- "You just said 'uterus.' What is that?"
- "What do you mean by 'effectiveness rate'?"

You can restate explanations in your own words to check that you understand. For example,

- "Are you saying that condoms are the only method that will help protect me from AIDS?"
- "You said I can stop this method on my own whenever I want?"

You can ask about how to continue using a method if you wish. For example,

- "When do I need to come back?"
- "How much does the method cost? Where do I buy it?"

If you are already using a family planning method, you can ask about any problems you are having. For example,

- "Is it true what I heard about my family planning method?"
- "Why did my monthly bleeding stop?"

The answers to these questions can help you make choices. We want to help you choose the method that best suits your needs.

How Much Information? How Much Guidance?

How much information and how much guidance do family planning clients need? These are two important practical questions facing those concerned with client-provider communication for informed choice. Research on people's medical decision-making finds great variation in how much information and how much guidance people want (116, 118). Some clients want to make family planning decisions completely on their own. Others want substantial help from a provider (285). The challenge for family planning providers is ascertaining and meeting those individual needs while meeting the ethical obligation to try to help every client make informed choices.

To help clients make informed choices about contraceptive use, family planning programs once thought providers should give clients a lot of information about all methods equally. This approach, however, overloaded clients with technical information and did little to help them apply information to their own lives (403).

People can generally assimilate two or three important pieces of information in a brief time. Receiving too much information is stressful (244). Particularly when they are passive listeners, clients forget or distort much of what providers tell them (100). If a client experiences fear, stress, or anxiety, information takes longer to assimilate. If clients become confused by an overload of information, they often do not use family planning well and are more likely to discontinue contraception than when clients receive clear, concise counseling (193).

In this Bangladesh community a health worker meets with a couple to counsel them on their family planning choices. People often differ widely in how much information they want.

Shared Decision-Making and Informed Choice

Some studies have found that patients do not want to make their own health decisions—particularly when these decisions could have serious consequences (57, 118). Instead they prefer to leave these decisions to others, including physicians and family members (37, 156, 336, 420). Most studies of medical decision-making, however, favor shared decision-making over a model in which the provider makes the decision alone (73). In shared decision-making the provider involves the patient in the decision-making process, recognizing the need to weigh patients' personal information in treatment decisions (74, 99, 171).

The informed choice model goes a step further than shared decision-making: clients make family planning decisions for themselves. The provider still has an important role, however. The provider's role is to help the client think through the decision-making process, focus on key issues, and evaluate options (31, 74, 100). Also, the provider makes sure clients' decisions are well informed. In these important ways, family planning decisions differ from other, more complex reproductive health matters such as STI and AIDS treatment, complications of pregnancy, and postabortion care, as well as such medical decisions as major surgery and cancer treatment, where leaving decisions entirely to the patient often increases their anxiety and creates feelings of abandonment (37, 156, 336, 420).

Studies show that, when family planning clients have good information, they are often as capable as providers of correctly assessing their own health risks and avoiding inappropriate contraceptive choices (113, 475). For example, in rural Mexico both pill users and nonusers were as likely to know whether they had high blood pressure or heart disease as providers were to diagnose these conditions (474).

What Providers Can Do

Because clients differ substantially in the amount of information and guidance they want in making family planning decisions, the provider needs to find out efficiently and ethically what the client already knows and has decided and also how much more information and guidance the client wants. Today programs increasingly advocate that providers tailor and personalize information to help individual clients think through their choices (98, 100, 118, 149, 272).

Providers can ask clients how much they want to know and then provide the information that is relevant and that the client can consider (299). Using common language that clients understand, while avoiding technical terms, helps clients understand and remember information. Providers can repeat the most important information and give clients time to review the information, if they need more time for consideration (100). Providers also can give clients permission to make their decisions at their own pace, even if that means putting off an immediate decision in order to consult a spouse or family member.

If clients say that they want the provider to decide for them, providers should respect this desire. Providers can describe the concept of informed choice, explain how the client will benefit from taking a part in decision-making (358), and try to involve the client in the process to some degree (99, 146, 171, 358). Respect for clients' autonomy is a principle of informed choice and a component of many health care professions' codes of ethics (198, 470).

planning decisions for their clients because they know what is best (102, 119, 244).

Providers sometimes erect barriers based on people's age, marital status, or other inappropriate criteria (178, 289). In particular, many providers deny family planning services to unmarried young people (195, 247). In a 1994 survey in Ghana, for example, 26% of providers said that marriage was a prerequisite to obtain family planning services. Some 76% of providers enforced minimum age requirements for contraception because they thought that access to contraception leads young adults to behave promiscuously (423).

Providers often have their own preferences and preconceived ideas about what contraceptive method is best for clients (102, 193, 378, 410). In a 1993 study in Jamaica, 90% of physicians said they preferred the pill for women who want to delay their first pregnancy, and 40% said they opposed at least one family planning method, usually injectables or fertility awareness-based methods (176).

In India a 1994 study found that most providers were influenced by the program's method-specific targets of that time and thus chose sterilization, the IUD, and to a lesser extent the pill for their female clients (255, 446). Also, in Kenya a reason that IUD use declined dramatically over a 10-year period was that many service providers were biased against the method (400).

A balanced presentation is best—a discussion of both positive and negative aspects of methods (2, 413, 421). When providers become more aware of their own biases and perceptions, they are better able to avoid making choices for their clients and instead help clients make informed decisions for themselves. One indication of an individual provider's bias toward certain methods is a contraceptive method mix among one provider's clients that differs drastically from that of other providers' clients. Similarly, if the contraceptive method mix among clients of a certain clinic is skewed toward a particular method, provider bias may be the reason (41, 382).

To help overcome bias, role-playing exercises and discussion groups with clients can help providers understand how their behavior affects clients' choices (69, 128, 358). Behavior modeling—that is, presenting examples of positive counseling behavior—can help providers improve their interaction with clients (325, 374).

Becoming comfortable with sexuality. Family planning providers can be uncomfortable or uncertain about sexual issues themselves and avoid discussing them, and many assume that clients do not want to talk about them either (34, 294, 300). Without discussion of sexuality, however, many clients are likely to make poorly informed family planning choices (100, 294).

For many clients the counseling session is the only opportunity to talk about sexual matters, which makes them eager to discuss such issues. In Egypt 71% of clients who received counseling about sexuality said they were not embarrassed. As one client said, "If the doctor asks us,...we would tell her about our problems, but otherwise I would be embarrassed to tell her" (3). Training that invites staff members to reflect on their own feelings and experiences about sexuality can help make them more comfortable discussing the topic with clients (34, 294).

Narrowing social distance. Differences between providers and clients in social class, education levels, scientific knowledge, and other types of status often interfere with good client-provider communication. Sometimes, providers treat clients of high socioeconomic status differently from those of low socioeconomic status (139, 429). Providers are particularly likely to believe they know what is best for poor clients. High-status service providers often underestimate their lower-status clients and thus make decisions for them (429). For example, in a 1993 Bolivian study many Aymara clients said providers often were rude or patronizing and offered the IUD as the only contraceptive option, without explaining side effects (370).

Providers and clients often have different health beliefs and different ways of understanding how the body works and what causes illness. Typically, the provider's understanding is based on science, while the client's is based on tradition, popular accounts, and informal discussions (166, 188).

Clients rarely mention their own health beliefs unless providers ask about them, but they often reject information that does not fit their own beliefs (110, 150, 157, 254). Providers can narrow such distances in understanding by expressing respect for the client's beliefs and drawing connections between these beliefs and the medical model of health (188).

Addressing gender. Gender roles—roles that a culture considers appropriate for a man or a woman—are little discussed but often affect the way providers and clients interact and the decisions that clients make. When clients are women, providers are less likely to answer questions, provide technical information, offer alternatives for treatment, and diagnose and treat certain diseases, and they are more likely to attribute clients' complaints to psychosomatic factors (242, 321).

Providers sometimes assume that men do not want to make family planning decisions or use contraception. In effect, such providers make men's choices for them, providing one

Rick Maiman, Courtesy of the David and Lucile Packard Foundation

Men need to know about family planning, too. Providers sometimes assume that men do not want to make family planning decisions or to use contraception. Counseling men, as in this clinic in Mexico, can encourage their participation.

JHU/CCP

A health care worker meets with a group of people in a Peruvian community. As people learn more about reproductive health, they are better able to participate actively in family planning decisions.

explanation for the fact that male-oriented contraceptive methods are used much less widely than female-oriented methods (111, 429).

To help address gender issues related to family planning decisions, providers can ask each client how much he or she wants other people to be involved in his or her family planning decision. If other family members oppose a client's own family planning wishes, and if the client is comfortable talking about the issue, the provider can invite the client's spouse or other family member to discuss the different family planning options and explain why family planning decisions are best made by clients themselves (77, 298).

When being counseled together with their partners, however, women participate less than when counseled alone and may have less influence over family planning decisions. In Kenya, for example, male clients communicated more actively than female clients during counseling as couples. Men volunteered extra information or asked questions during 66% of their turns to speak compared with 27% for women. Providers offered more detailed information to the men than to the women, and men had more influence over the session's content, direction, and duration (242).

Training can help providers, both male and female, better understand gender roles. When providers understand how gender influences such life issues as spousal communication, childbearing intentions, and domestic violence, they are better able to help clients make informed family planning choices (106, 186, 326).

Active Clients

Clients who participate actively in the counseling process—that is, who ask questions, state opinions, express concerns, and freely offer relevant personal information—make better health decisions (105, 230, 346). When clients play an active role in their family planning decisions, they have more confidence in the outcome and are more likely to follow through (201, 244).

Clients need encouragement to be active in counseling (373). Most clients feel more comfortable speaking out when prompted by the provider. Clients who have had little contact with family planning providers often do not know what is expected from them in a health care setting. Many think that providers do not want them to ask questions or are afraid of wasting providers' time. Some are passive because they worry about appearing ignorant, while others do not want to challenge the provider's authority (14, 353). Clients are particularly reluctant to ask questions when they think "the provider knows best," and they accept a method urged by the provider even if it is not their own choice.

Providers sometimes believe incorrectly that, when clients are quiet, they have no questions or concerns. Usually, however, their silence indicates lack of confidence to ask questions and the practice of waiting for the provider's cues before speaking (37, 68). Providers often do not give clients enough information to play an active role (14, 137). Although asking clients a lot of questions does not always increase active client communication (173, 243), providers who are supportive—offering reassurance, approval, and constructive suggestions—usually help clients participate more (248).

Providers can assure clients that they can speak frankly even about sensitive matters and that nothing said will be discussed with anyone else (299). They can ask clients to express their feelings and to feel free to talk about their personal situation (38). Providers can encourage clients to tell their own story, talking about what they want to talk about, without guiding clients in any particular direction (391). This approach can efficiently bring out what is most important to the client.

Increasing client participation. Family planning programs can increase client participation by making more productive use of the time that clients spend at clinics and by training clients in active participation. The time that clients spend waiting can be an opportunity for learning (14, 353, 416). If clients learn more about the range of available contraceptive methods before seeing a provider, the provider can better focus on methods that interest the client (245).

Before counseling, clients can prepare by completing a checklist that covers questions they may have for the provider (447) (see list, p. 27). Showing a video that models active clients, offering reading materials, or holding an active waiting room discussion also can help (13, 230, 408).

Programs also can train clients to be more active participants in decision-making. Research, mostly in developed countries in health fields other than family planning, has found that training helps clients seek information more effectively, tell providers more about their health condition, and verify the information they receive from providers (68, 353, 394). Training clients in active behavior also increases the amount of information that they obtain and remember from counseling sessions (394). Client training can cover the right to make informed choices about family planning; the skills to obtain information; the skills to make family planning decisions; and assertiveness in communicating with providers (230, 250, 394).

Clients are more likely to ask questions when they can think about them ahead of time (416). In 2000 an Indonesian pilot project, "Smart Patient," worked with 525 clients individually to write their questions, prioritize them, and then rehearse asking them. The training gave clients confidence that they could ask questions during counseling. Evaluation found that clients who received coaching spoke significantly more often than other clients, asking on average 5.5 questions compared with 3.5. Also, coached clients voiced an average of 5.6 concerns compared with 4.5 concerns among

clients without coaching. Although the project would be difficult to implement in all clinics nationwide, it demonstrates that preparing clients in advance leads to more active client behavior (250).

Helping Clients Make Informed Choices

Any staff member can learn to counsel clients for informed choice. Everyone on the family planning staff can be oriented to effective client-provider communication and to the principle of informed choice (21, 403).

Providers can help achieve informed choice best through client-centered counseling, in which clients' concerns, desires, and comfort are most important, and clients lead the exchange (244). Client-centered counseling leads to better family planning decisions (114, 295, 432). In Egypt, for example, contraceptive continuation rates seven months after counseling were higher and client satisfaction was three times higher when counseling sessions were client-centered than when sessions were provider-centered (4).

The Maximizing Access and Quality (MAQ) Initiative has developed six principles in client-provider interaction for use in family planning services that can foster informed choice (298). These principles focus on treating each client well, providing the client's preferred method, and offering relevant information and guidance. Similarly, the six-step GATHER process helps counselors and clients through a decision-making process that informs clients' choices (see **Population Reports,** *GATHER Guide to Counseling,* Series J, No. 48, Dec. 1998).

Method preferences. As a first step, providers can ask, "What can we do for you today?" and then ask new clients if they have a particular family planning method in mind. Usually the methods that clients prefer are the best methods for them. Providers can discuss the preferred method, asking clients to explain in their own words what they have heard about the method, without challenging or insulting them (100, 348). Providers also can name other contraceptive methods that are available and ask whether clients would like to hear more about any or all of them (298). Even if clients do not want to hear about them, they will at least know there are other methods if their needs change.

Before clients decide on a method, however, providers should be sure to tell them that condoms are the only contraceptive method that protects against STIs (see box, p. 10). Family planning programs can integrate STI/HIV counseling into their programs by helping all clients understand their own risk of infection and, where appropriate, offering testing. Providers can help HIV-positive women to understand the risk of transmitting HIV to the child if they become pregnant and to weigh the decision whether or not to have children (9).

Some providers are so resolved to avoid making choices for clients that they discuss all methods equally rather than focus on the methods that interest the client (244). It is not necessary—as was once argued—to tell each client individually everything about every contraceptive method (see box, p. 28).

Many providers do not ask clients if they prefer a particular contraceptive method. The percentage varies widely from country to country. According to Situation Analyses in 12 sub-Saharan African countries between 1992 and 1997, at the low end of the range was Burkina Faso, where providers asked 48% of new family planning clients what method they preferred. At the high end was Senegal, at 82% (289).

Sometimes, clients' initial preferences are based on inaccurate information. To ensure that these choices are informed, providers can ask, without conveying disapproval or approval, that clients explain their choice (244, 348). Research found that providers in Ecuador asked 99% of new clients their reasons for choosing their method, in Zimbabwe, 87% of clients, and in Uganda, 73% (407) (see Figure 4).

For new clients who do not already have a contraceptive method in mind, learning their specific interests—for example, spacing or limiting births, emergency contraception, or protection from STIs—helps focus discussion on the methods of most interest (139). Providers can ask clients what they would like to know about family planning (100, 348), tailor information based on what the client wants to know, and help clients consider what attributes they want in a method (31, 299).

JHU/CCP

Active clients can make better health decisions. In Indonesia the "Smart Patient" project worked with over 500 family planning clients individually to help them become more active in counseling sessions. Training gave clients confidence to speak up during counseling, to ask questions, and to voice concerns.

The percentage of providers who discuss contraceptive methods in detail with their clients varies. According to research among more than 15,000 clients in eight Latin American countries, 83% of clients said the time spent in consultation was enough to address their needs, 88% said they had the opportunity to ask questions and clarify doubts, and 90% said use of the method was explained clearly (459). Research in Kenya found that providers explained how the method works in 56% of consultations (300). In Uganda providers told 94% of clients how to use the selected method compared with 83% in Ecuador and 85% in Zimbabwe (407) (see Figure 4).

The contraceptive information that providers give or fail to give in counseling sessions can be crucial to effective contraceptive use. In a clinic in Kenya, for example, women experiencing contraceptive failures were over three times more likely to report receiving inadequate information about their method than other women using the same method (307). As a South African woman explained, "I had been on the pill and I came off it and I was given one of these gel things to use and I didn't really know how it worked and I fell pregnant. After that I've learned a lot more about it" (167).

Counseling about side effects before clients begin use of a method is particularly important in helping clients make informed choices, so that they can choose another method if they prefer. For example, in China continuation rates for injectables were higher when providers told women in advance about possible changes in menstrual bleeding patterns than when they did not tell clients, partly because women who would find such changes intolerable chose a different method instead (267).

Counseling about side effects is also important for contraceptive continuation (92, 141, 191, 193, 458). In Niger, for example, only 19% of women who said they received adequate information about side effects discontinued contraceptive use within six to eight months compared with 37% of women who said they received inadequate information. In The Gambia the difference was even greater—14% compared with about 50% (89).

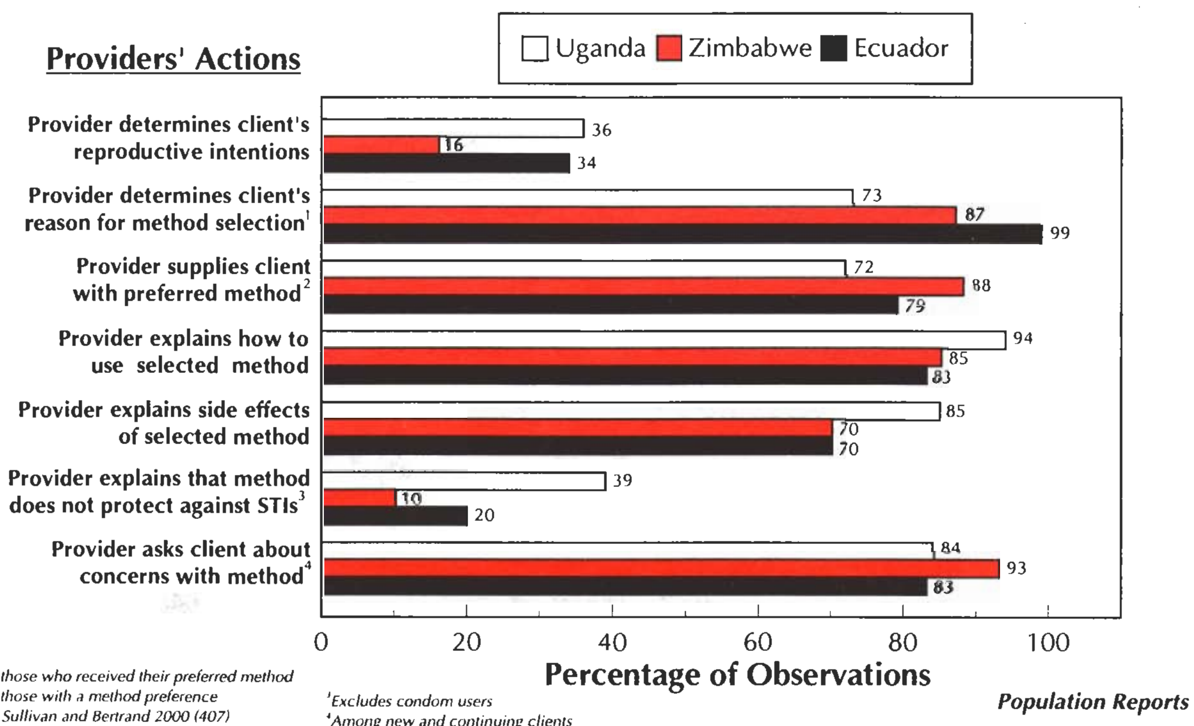
Nevertheless, not all providers counsel clients about contraceptive side effects. In Uganda 85% of clients were told about side effects, 70% in Zimbabwe, and 70% in Ecuador (407). In Kenya client exit interviews found that service providers told the client what to do if there were side effects in 76% of consultations, described possible side effects in 60% of consultations, and asked if the client had any questions in 60% of consultations (300).

Screening for medical eligibility. The final step in helping a person choose a contraceptive method is screening for medical reasons that prevent its safe use. Once a client has a clear preference for a method, the provider can ask about specific medical conditions that would prevent safe use. A provider can help the client weigh and compare the risks and benefits of both pregnancy and use of that particular family planning method (258). Where use of a method is clearly ruled out for medical reasons and the client is unable to obtain her preferred method, the provider can explain why and help her choose another.

Continuing clients. The decision to continue using a contraceptive method should be as well informed as an initial choice. Asking continuing clients whether they have any

Figure 4. Ensuring Informed Choices in the Clinic

Provider Actions with New Family Planning Clients, Based on Observation of Counseling Sessions



[1]Among those who received their preferred method
[2]Among those with a method preference
Source: Sullivan and Bertrand 2000 (407)

[3]Excludes condom users
[4]Among new and continuing clients

Population Reports

problems with their current method invites clients to think about possible doubts that might lead to discontinuation. An essential component of informed choice and client satisfaction is telling clients they have the option to switch methods whenever and as often as needed (59).

Still, many providers do not offer this information during counseling. For example, in Kenya in 1995, of 224 new clients surveyed, 41% had been told they had the option to switch if they became dissatisfied with their method (303). In Zimbabwe a similar study in 1996 found that, of 168 new clients surveyed, just 13% were told they had the option to switch (112).

High method continuation rates sometimes indicate that people do not know they can switch or that they have a limited choice of methods (10). For instance, research in Indonesia found that continuation rates among implant users were four times higher than among IUD users, in part because implant users did not know that removal before five years was possible, while IUD users knew the IUD could be removed at any time (419).

When people stop using a certain contraceptive, it may not be because they are dissatisfied with their method, however. People who stop a method after long-term use usually do so because their reproductive needs or intentions have changed (10, 138, 291). Such change is to be expected and does not necessarily imply problems with the original choice of method. Rather, people are making a choice that better reflects their needs (110, 139).

Whether considering starting family planning, choosing among methods, or continuing use, people can make healthier decisions if they make informed choices—that is, choices they make for themselves, based on accurate information and a range of contraceptive options. Family planning programs and providers, along with governments and donor agencies, can do much to help people make informed family planning choices.

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Bibliography

An asterisk (*) denotes an item that was particularly useful in the preparation of this issue of **Population Reports.**

1. ABATE, A. Population will reach 129 million in 2030. The Daily Monitor (Addis Ababa), Nov. 28, 2000. p. 1.
2. ABDEL-TAWAB, N. The Clinical Services Improvement Project (PCSI) counseling training program: Impact on providers and clients in Egypt. Baltimore, Johns Hopkins School of Public Health, Population Communication Services, Jun. 1993. 39 p.
3. ABDEL-TAWAB, N., NAWAR, L., YOUSSEF, H., and HUNTINGTON, D. Integrating issues of sexuality into Egyptian family planning counseling. Frontiers report. Cairo, Egypt, Population Council, Frontiers in Reproductive Health, Mar. 26, 2000. 47 p. (Available: <http://www.popcouncil.org/ pdfs/frontiers/egypt_sex.pdf>, Accessed Mar. 8, 2001)
4. ABDEL-TAWAB, N. and ROTER, D. The relevance of client-centered communication to family planning settings in developing countries: Lessons from the Egyptian experience. Social Science and Medicine. (Forthcoming)
5. ABECASSIS, A.F. History of contraception in France. SOINS, Gynecologie, Obstetrique, Puericulture, Pediatrie (141): 5-11. Feb. 1993.
6. ADAIR, L.S., VISWANATHAN, M., POLHAMUS, B., GULTIANO, S., and AVILA, J. Cebu longitudinal health and nutrition survey follow-up study. Final report to the Women's Study Project. Research Triangle Park, North Carolina, Family Health International, University of San Carlos, 1997. (Available: <http://www.fhi.org/en/wsp/wsfinal/fctshts/wsfct22.html>, Accessed Apr. 4, 2001)
7. ADEWUYI, A., AJAEGBU, H., AYOOLA, G., BABALOLA, S., ESIMAI, G., KISSEKA, M., OMIDEYI, K., THOMAS, K., ASKEW, I., and MENSCH, B. Nigeria: The family planning situation analysis study. Final report. New York, Population Council, Africa Operations Research and Technical Assistance Project, Nov. 1992. 30 p.
8. AGHAJANIAN, A. and MERHYAR, A.H. Comment: Fertility, contraceptive use and family planning program activities in the Islamic Republic of Iran. International Family Planning Perspectives 25(2): 12. Jun. 1999.
9. AKA-DAGO-AKRIBI, H., DU LOU , A.D., MSELLATI, P., DOSSOU, R., and WELFFRENS-EKRA, C. Issues surrounding reproductive choice for women living with HIV in Abidjan, Côte d'Ivoire. Reproductive Health Matters 7(13): 20-29. May 1999.
10. ALI, M. and CLELAND, J. Contraceptive discontinuation in six developing countries: A cause-specific analysis. International Family Planning Perspectives 21(3): 92-97. Sep. 1995.
11. ALI, N., WELLS, E., and SUTTON, D. Reviewing print material for oral contraceptives: Direction for the future. Washington, D.C., Program for Appropriate Technology in Health, Jul. 9, 1998. 70 p.
12. AMIN, R., BECKER, S., and BAYES, A. NGO-promoted microcredit programs and women's empowerment in rural Bangladesh: Quantitative and qualitative evidence. Journal of Developing Areas 32(2): 221-236. Winter 1998.
*13. ANDERSON, J.M. Empowering patients: Issues and strategies. Social Science and Medicine 43(5): 697-705. Sep. 1996.
14. ANDERSON, L.A., MCEVOY DEVELLIS, B., and DEVELLIS, R.F. Effects of modeling on patient communication, satisfaction, and knowledge. Medical Care 25(11): 1044-1056. Nov. 1987.
15. APROPO and SOCIAL MARKETING FOR CHANGE (SOMARC). APROPO establishes an innovative agreement with commercial partners to contribute $50,000 up front to their CSM project. SOMARC II Highlights: 1-2. Dec. 1992.
16. ARTICLE 19. Standards and recommendations. In: Coliver, S. The Right to Know: Human Rights and Access to Reproductive Health Information. London, Article 19, 1995. p. 327-355.
17. ASHOKE, S., KANE, T.T., and HAMAL, H. Contraceptive social marketing in Nepal: Consumer and retailer knowledge, needs and experience. Journal of Biosocial Sciences 22: 305-322. 1990.
18. ASIA WEEK. Philippines. Church vs. State: Fidel Ramos and family planning face "Catholic Power". Asia Week Aug. 24, 1994. p. 21-22.
19. ASKEW, I., MENSCH, B., and ADEWUYI, A. Indicators for measuring the quality of family planning services in Nigeria. Studies in Family Planning 25(5): 268-283. Sep./Oct. 1994.
20. ASOCIACION HONDURENA DE PLANIFICACION FAMILIAR (ASHONPLAFA) and FAMILY HEALTH INTERNATIONAL. Purchasers of oral contraceptives in a social marketing program in Honduras: Final report. Tegucigalpa, Honduras, ASHONPLAFA, Oct. 1987. 77 p.
21. ASSOCIATION FOR VOLUNTARY SURGICAL CONTRACEPTION (AVSC). Informed consent and voluntary sterilization. An implementation guide for program managers. New York, AVSC, 1988. 31 p.
*22. AVSC INTERNATIONAL. Informed choice. New York, AVSC International, Folder. 1998.
23. AVSC INTERNATIONAL. Informed choice in family planning: Legacies and challenges. New York, AVSC International, 1998. 2 p.
24. AVSC INTERNATIONAL. Leadership in informed choice. New York, AVSC International, 1998. 4 p.
25. AVSC INTERNATIONAL. Informed choice assessment: Discussion guidelines. New York, AVSC International, 2000. 7 p.
26. BAAH-BOAKYE, E.A. Husband-wife communication in family planning decisions in urban Ghana. May 1988. 109 p. (Unpublished)
27. BANDURA, A. Social foundations of thought and action: A social cognitive theory. Englewood Cliffs, New Jersey, Prentice Hall, 1986.
28. BANGLADESH FAMILY PLANNING SOCIAL MARKETING PROJECT. Evaluation of illustrated support material of Maya pill. 1982. 22 p. (Unpublished)
29. BANKOLE, A. and SINGH, S. Couples' fertility and contra-

ceptive decision-making in developing countries: Hearing the man's voice. International Family Planning Perspectives 24(1): 15-24. Mar. 1998.
30. BARKAT-E-KHUDA, MIRZA, T., and AHMED, S. Lessons learned on doorstep delivery of injectable contraceptives. Proceedings of the Workshop by the International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B) and the Maternal and Child Health-Family Planning (MCH-FP) Extension Project, Dhaka, Bangladesh, Sep. 28, 1994. ICDDR,B, MCH-FP, 78 p.
31. BARNETT, B. Clients prefer method choices. Network 19(1): 14-18. Research Park Triangle, North Carolina, Family Health International. Fall 1998.
32. BARNETT, B. First-time users have diverse needs. Network 19(4): 4-7. Research Triangle Park, North Carolina, Family Health International. Summer 1999.
33. BARNETT, B. and STEIN, J. Women's voices, women's lives: The impact of family planning. North Carolina, The Women's Studies Project, Jun. 1998.
34. BECKER, J. and LEITMAN, E. Introducing sexuality within family planning: The experience of the HIV/STD prevention projects from Latin America and the Caribbean. New York, Population Council, 1998. (Quality/Calidad/Qualite No. 8) 28 p.
35. BEDIMO, A.L., BESSINGER, R., and KISSINGER, P. Reproductive choices among HIV-positive women. Social Science and Medicine 46(2): 171-179. Jan. 1998.
36. BEGUM, H. Health care, ethics and nursing in Bangladesh: A personal perspective. Nursing Ethics 5(6): 535-541. Nov. 1998.
37. BEISECKER, A.E. and BEISECKER, T.D. Patient information-seeking behaviors when communicating with doctors. Medical Care 28(1): 19-28. Jan. 1990.
38. BERTAKIS, K.D., ROTER, D., and PUTNAM, S.M. The relationship of physician medical interview style to patient satisfaction. The Journal of Family Practice 32(2): 135-136. Feb. 1991.
39. BERTRAND, J.T., HARDEE, K., MAGNANI, R.J., and ANGLE, M.A. Access, quality of care, and medical barriers in family planning programs. International Family Planning Perspectives 21(2): 64-74. Jun. 1995.
40. BERTRAND, J.T. and KINCAID, L.D. Evaluating Information-Education-Communication (IEC) programs for family planning and reproductive health. Final report of the IEC Working Group. Chapel Hill, North Carolina, Carolina Population Center, University of North Carolina at Chapel Hill, Tulane University Center for International Health and Development, The Futures Group, Oct. 1996. 161 p.
41. BERTRAND, J.T., RICE, J., SULLIVAN, T.M., and SHELTON, J. Skewed method mix: A measure of quality in family planning programs. Chapel Hill, North Carolina, MEASURE Evaluation, Carolina Population Center, University of North Carolina at Chapel Hill, May 2000. 41 p. (Available: <http://www.cpc.unc.edu/measure/publications/workingpapers/wp0023ab.html>)
42. BEST, K. CARE project enlists community support. Network 17(2): 11-13. Research Triangle Park, North Carolina, Family Health International. Spring 1999.
43. BEST, K. City life isolates many clients. Network 17(2): 13. Research Triangle Park, North Carolina, Family Health International. Spring 1999.
44. BEST, K. Social contacts influence method use. Network 19(4): 12-15. Research Triangle Park, North Carolina, Family Health International. Summer 1999.
45. BHUSHAN, I. Understanding unmet need. Baltimore, Johns Hopkins University Center for Communication Programs, Nov. 1997. (Available: <http://www.jhuccp.org/ pubs/working_papers/wp4/contents.html>)
46. BIDDLECOM, A.E. and FAPOHUNDA, B.M. Covert contraceptive use: Prevalence, motivations, and consequences. [Policy Research Division Working Papers No. 108]. New York, Population Council, 1998. 37 p.
47. BITRAN, R.A. and MCINNES, D.K. The demand for health care in Latin America. Lessons from the Dominican Republic and El Salvador. Proceedings of the EDI, Washington, D.C., 1993. World Bank, 54 p.
48. BLACKBURN, R. New contraceptive choices. [Outline]. Population Reports, Series M, No. 16. Baltimore, Johns Hopkins University Bloomberg School of Public Health, Population Information Program, Nov. 2000. 3 p.
49. BLANEY, C.L. Long-acting methods require special care. Network 15(1): 18-21. Research Triangle Park, North Carolina, Family Health International. Aug. 1994.
50. BLANEY, C.L. Important needs follow pregnancy. Network 17(4). Research Triangle Park, North Carolina, Family Health International. Summer 1997. (Available: <http://www.fhi.org/>)
51. BLUMENTHAL, P.D. and MCINTOSH, N. Pocket guide for family planning providers 1996-1998. 2nd ed. Oliveras, E., ed. Baltimore, Johns Hopkins Program for International Education in Reproductive Health, 1996. 399 p.
52. BONGAARTS, J. and WATKINS, S.C. Social interactions and contemporary fertility transitions. [Research Division Working Papers No. 88]. New York, Population Council, 1996. 69 p.
53. BOSVELD, W. Explaining between-country variation in fertility: The theoretical link between individual behaviour and social context. Amsterdam, Postdoctorale Onderzoekersopleiding Demografie, Aug. 1998. (Nethur-Demography Paper No. 41) 17 p.
54. BOULAY, M. Change in social networks and the adoption of family planning: A study in rural Nepal. Presented at the 20th International Sunbelt Social Network Conference, Vancouver, B.C., Apr. 13-15, 2000.
55. BOULAY, M. The influence of information-seeking strategies on social network composition and contraceptive adoption among women in rural Nepal. Presented at the Annual Meeting of the Population Association of America, Los Angeles, Mar. 23-25, 2000. Johns Hopkins University Bloomberg School of Public Health, Center for Communication Programs. 40 p.
56. BOULAY, M., STOREY, D.J., and SOOD, S. Indirect exposure to a family planning mass media campaign in Nepal. [Draft]. Baltimore, Johns Hopkins University, Center for Communication Programs, Nov. 4, 1999.
57. BRADDOCK, C.H., EDWARDS, K.A., HASENBERG, N.M., LAIDLEY, T.L., and LEVINSON, W. Informed decision making in outpatient practice: Time to get back to basics. Journal of the American Medical Association 282(24): 2313-2320. Dec. 1999.
58. BRADLEY, J., BRUCE, J., DIAZ, S., HUEZO, C., and MWORIA, K. Using COPE to improve quality of care: The experience of the family planning association of Kenya. New York, Population Council, 1999. (Quality/Calidad/Qualite No. 9) 19 p. (Available: <http://www.popcouncil.org/publications/qcq/qcq09.pdf>, Accessed Mar. 21, 2001)
*59. BRUCE, J. Fundamental elements of the quality of care: A simple framework. Studies in Family Planning 21(2): 61-91. Mar./Apr. 1990.
60. BRUCE, J. and JAIN, A. Improving the quality of care through operations research. In: Seidman, M. and Horn, M.C. Operations Research: Helping Family Planning Programs Work Better. New York, Wiley-Liss, 1991. p. 259-282.
61. BUTTA, P. Informed consent and voluntary sterilization: An implementation guide for program managers. New York, AVSC International, 1995. 26 p.
62. CACHAN, J. and MARSHALL, M. Implementing reproductive health awareness: Progress to date. Advances in Contraception 13(2-3): 363-371. Jun./Sep. 1997.
63. CARIGNAN, C.S., IPPOLITO, L., and NERSESIAN, P.V. SEATS II: Clinical protocols for family planning programs: A resource book. Volume I. AVSC International and John Snow, Oct. 1995.
64. CARLOS, A.C. Trends and directions. In: Carlos, A.C. Male Involvement in Family Planning: Programme Initiatives. London, International Planned Parenthood Federation, 1984. p. 1-8.
65. CASTRO MARTIN, T. The impact of women's education on fertility in Latin America: Searching for explanations. International Family Planning Perspectives 21(2): 52-57, 80. Jun. 1995. (Available: <http://www.agi-usa.org/pubs/journals/2105295.html>, Accessed Apr. 5, 2001)
66. CATES, W., JR., STEINER, M.J., and RAYMOND, E.G. Dual vs. duel(ing) protection against unintended pregnancy and sexually transmitted infections: What is the best contraceptive approach? [Draft]. Research Triangle Park, North Carolina, Family Health International, Jan. 8, 2001. 20 p.
67. CATINO, J. Meeting the Cairo challenge: Progress in sexual and reproductive health. Implementing the ICPD Programme of Action. New York, Family Care International, Oct. 1999. 190 p.
68. CEGALA, D.J. The effects of communication skills training on patients' participation during medical interviews. Presented at the Health Communication Division of the National Communication Association Meeting, Chicago, Illinois, Nov. 1999. Ohio State University. 31 p.
69. CENTER FOR HUMAN SERVICES, JOHNS HOPKINS UNIVERSITY, and JOINT COMMISSION INTERNATIONAL. Improving interpersonal communication between health care providers and patients. Core course. Reference manual 1999. Bethesda, Maryland, Center for Human Services, 1999. 40 p.
70. CENTER FOR REPRODUCTIVE LAW AND POLICY (CRLP). Women of the world: Laws and policies affecting their reproductive lives. Anglophone Africa. New York, CRLP, May 1997. 52 p.
71. CENTER FOR REPRODUCTIVE LAW AND POLICY (CRLP). Nothing personal: A human rights report on the provision of surgical sterilization in Peru, 1996-1998. New York, CRLP, Mar. 2000. 20 p.
72. CENTRE FOR DEVELOPMENT AND POPULATION ACTIVITIES (CEDPA). Institution-building for quality services. New York, United Nations. Population Division. Department for Economic and Social Information and Policy Analysis., 1996. p. 388-394.
73. CHARLES, C., WHELAN, T., and GAFNI, A. What do we mean by partnership in making decisions about treatment? British Medical Journal 319: 780-782. Sep. 18, 1999. (Available: <http://www.bmj.com/cgi/content/full/319/7212/780>, Accessed Jun. 18, 2001).
74. CHARLES, C., GAFNI, A., and WHELAN, T. Shared decision-making in the medical encounter: What does it mean? (or it takes at least two to tango). Social Science and Medicine 44(5): 681-692. Mar. 1997.
75. CHERKAOUI, M. Fertile changes. ORGYN: 27-32. 1995.
76. CHI, I.C. and JONES, D.B. Incidence, risk factors, and prevention of poststerilization regret in women: An updated international review from an epidemiological perspective. Obstetrical and Gynecological Survey 49(10): 722-732. Oct. 1994.
77. CHINA POPULATION TODAY. Quality services for Shanghai couples. Urban family planning programme. China Population Today, Vol. 14, No. 1, Feb. 1997. p. 9.
78. CHU, J. Quality reorientation of the family planning program in China: Some conceptual issues. Boston, Massachusetts, Harvard Center for Population and Development Studies, Dec. 1999. 41 p. (Available: <http://www.hsph.harvard.edu/grhf/HUpapers/chu.html>, Accessed Mar. 15, 2001)
79. CLARK, S. and SPIELER, J. Natural family planning: U.S. Agency for International Development policy considerations. In: Jennings, J.T., Spieler, J.M., Von Hertzen, H., and Queenan, V.H., eds. Proceedings of the Conference on Natural Family Planning: Current Knowledge and New Strategies for the 1990s, Washington, D.C., Dec. 10-14, 1990. p. 88-90.
80. CLARKE, L.L., SCHMITT, K., BONO, C.A., STEELE, J., and MILLER, M.K. Norplant selection and satisfaction among low-income women. American Journal of Public Health 88(8): 1175-1181. Aug. 1998.
81. CLELAND, J. and MAULDIN, W.P. The promotion of family planning by financial payments: The case of Bangladesh. Studies in Family Planning 22(1): 1-18. Jan./Feb. 1991.
82. CLELAND, J. and WILSON, C. Demand theories of the fertility transition: An iconoclastic view. Population Studies 41(1): 5-30. Mar. 1987.
83. COGGINS, C., LANGER, A., WINIKOFF, B., LAZCANO, E.C., HEIMBURGER, A., and SLOAN, N. Effectiveness of integration of self-screening of STDs into family planning programs. Presented at the American Public Health Association 126th Annual Meeting, Washington, D.C., Nov. 15-18, 1998.
84. COHEN, W.J. Freedom of choice (family planning). Studies in Family Planning 1(23): 2-5. Dec. 1964.
85. COLEY, K.C. Contraception: What pharmacists should tell their patients. American Pharmacy 33(9): 55-66. Sep. 1993.
86. COLIVER, S. Algeria. In: Coliver, S. The Right to Know: Human Rights and Access to Reproductive Health Information. London, Article 19, 1992. p. 99-120.
*87. COLIVER, S., ed. The right to know: Human rights and access to reproductive health information. London, Article 19, 1995. 391 p.
88. CONSORTIUM FOR EMERGENCY CONTRACEPTION and PROGRAM FOR APPROPRIATE TECHNOLOGY IN HEALTH (PATH). Medical and service delivery guidelines. <http://www.path.org/cec/html/medguide.htm>PATH, 2001.
89. COTTEN, N., STANBACK, J., MAIDOUKA, H., TAYLOR-THOMAS, J.T., and TURK, T. Early discontinuation of contraceptive use in Niger and The Gambia. International Family Planning Perspectives 18(4): 145-149. Dec. 1992.
*90. COTTINGHAM, J. Beyond acceptability: Users' perspectives on contraception. London, World Health Organization, 1997. p. 1-5.
91. CURTIS, S. and NEITZEL, K. Contraceptive knowledge, use, and sources. Calverton, Maryland, Macro International, Mar. 1996. (DHS Comparative Studies No. 19) 100 p.
92. CURTIS, S.L. and BLANC, A.K. Determinants of contraceptive failure, switching, and discontinuation: An analysis of DHS contraceptive histories. Calverton, Maryland, Macro International, Oct. 1997. (Demographic and Health Surveys Analytical Reports No. 6) 50 p.
93. DABIRI, O.M. The way forward: Nigeria's population. Oct./Dec. 1993. p. 30-31, 34.
94. DADIAN, M.J. Protection vs. protectionism? AIDS Captions 4(1): 9. Research Triangle Park, North Carolina, Family Health International. Jun. 1997.
95. DANIELS, D. and EDWARDS-LOPEZ, J. Overview of the EC's health, AIDS and population portfolio in developing countries (1990-1999). London, European Commission Council, Oct. 2000. 1 p. (Available: <http://europa.eu.int/comm/development/sector/social/pfolio3011_en.htm>)
96. DAVANZO, J. and GRAMMICH, C. Barren ground: Eastern Europe's transition from communism isn't the only factor affecting the region's demographics. <http://www.rand.org/popmatters/TOL.html>RAND, Population Matters, Jan. 3, 2001.
97. DAVID, H.P. and BABAN, A. Women's health and reproductive rights: Romanian experience. Patient Education and Counseling 28(3): 235-245. Jul. 1996.
98. DAVIS, A. and WYSOCKI, S. Clinician/patient interaction: Communicating the benefits and risks of oral contraceptives. Contraception 59(1 Suppl.): S39-42. Jan. 1999.
99. DEBER, R.B., KRAETSCHMER, N., and IRVINE, J. What role do patients wish to play in treatment decision making? Archives of Internal Medicine 156(13): 1414-1420. Jul. 8, 1996.
*100. DELBANCO, T.L. and DALEY, J. Through the patient's eyes: Strategies toward more successful contraception. Obstetrics and Gynecology 88(3 Suppl.): S41-47. Sep. 1996.
101. DEPARTMENT FOR INTERNATIONAL DEVELOPMENT (DFID). China. London, DFID, 2000. 1 p. (Available: <www.dfid.org.uk/public/what/advisory/group4/faq7.html>)
102. DIAZ, J. and DIAZ, M. Quality of care in family planning in Latin America. Advances in Contraception 9(2): 117-128. Jun. 1993.
*103. DIAZ, M., JASIS, M.I., PACHAURI, S., PINE, R.N., PLATA, M.I., RUMINJO, J., STEELE, C., TABBUTT-HENRY, J., and WIDYANTORO, N.S. Informed choice in international family planning service delivery. Strategies for the 21st century. New York, AVSC International, 1999. 22 p.
104. DIMATTEO, M.R. The physician-patient relationship: Effects on the quality of health care. Clinical Obstetrics and Gynecology 37(1): 149-161. Mar. 1994.
105. DIMATTEO, M.R., REITER, R.C., and GAMBONE, J.C. Enhancing medication adherence through communication and informed collaborative choice. Health Communication 6(4): 253-265. Oct./Dec. 1994.
106. DIXON-MEULLER, R. Gender inequalities and reproductive health: Changing priorities in an era of social transformation and globalisation. Belgium, International Union for the Scientific Study of Population, 1999. (Policy and Research Paper No. 16) (Available: <www.iussp.org/Publications_on_site/PRP/ prp16.htm>)
*107. DIXON-MUELLER, R. Population policy and women's

rights: Transforming reproductive choice. Westport, Connecticut, Praeger, 1993. 300 p.
108. DKT INTERNATIONAL (DKT). 1998 contraceptive social marketing statistics. Washington, D.C., DKT, Sep. 1999. 8 p.
109. DONABEDIAN, A. The quality of care: How can it be assessed? Journal of the American Medical Association 260(12): 1743-1748. Sep. 23-30, 1988.
110. DONOVAN, J.L. Patient decision making: The missing ingredient in compliance research. International Journal of Technology Assessment in Health Care 11(3): 443-455. Summer 1995.
111. DRENNAN, M. Reproductive health: New perspectives on men's participation. Population Reports, Series J, No. 46. Baltimore, Johns Hopkins School of Public Health, Population Information Program, Oct. 1998. 35 p.
112. DUBE, H.M.B., MARANGWANDA, C.S., and NDHLOVU, L. An assessment of the Zimbabwe family planning programme. Results from the 1996 situation analysis study. Harare, Zimbabwe, Zimbabwe National Family Planning Council, Population Council, May 1998. 53 p.
113. DUCLAYAN, G. and HAREL, K. When choosing a contraceptive, women know best. Momentum: News from the Population Council [Newsletter], Sep. 1999. p. 8-9.
114. EDMUNDS, M., STRACHAN, D., and VRIESENDORP, S. Client-responsive family planning: A handbook for providers. Watertown, Massachusetts, Pathfinder Fund, 1987. 93 p.
115. EDOZIEN, L. Counselling for female sterilisation. British Journal of Family Planning 23(1): 14-15. Apr. 1997.
116. EDWARDS, A. and ELWYN, G. The potential benefits of decision aids in clinical medicine. Journal of the American Medical Association 282(8): 779-780. Aug. 25, 1999.
117. EGYPT. CENTRAL AGENCY FOR PUBLIC MOBILIZATION AND STATISTICS (CAPMAS), WOMEN AND CHILD RESEARCH UNIT, and UNITED NATIONS CHILDREN'S FUND (UNICEF) EGYPT. The situation of women in Egypt. Cairo, CAPMAS, UNICEF, 1991. 61 p.
118. ENDE, J., KAZIS, L., ASH, A., and MOSKOWITZ, M.A. Measuring patients' desire for autonomy: Decision making and information-seeking preferences among medical patients. The Journal of General Internal Medicine 4(1): 23-30. Jan./Feb. 1989.
119. ENE, E.N. Family planning, fertility control and the law in Nigeria: The choices for a new century. African Journal of Reproductive Health 2(2): 82-95. Oct. 1998.
120. ENGENDERHEALTH. Building coalitions. <http://www.engenderhealth.org/ia/foc/focbc.html> EngenderHealth, Apr. 9, 2001.
121. ENTWISLE, B., RINDFUSS, R.R., GUILKEY, D.K., CHAMRATRITHIRONG, A., CURRAN, S.R., and SAWANGDEE, Y. Community and contraceptive choice in rural Thailand: A case study of Nang Rong. Demography 33(1): 1-11. Feb. 1996.
122. EVALUATION PROJECT, SERVICE DELIVERY WORKING GROUP, and QUALITY SUBCOMMITTEE. Indicators of quality of care in family planning programs. Mar. 31, 1993. 7 p. (Unpublished)
123. EVANS, I. and HUEZO, C., eds. Family planning handbook for health professionals: The sexual and reproductive health approach. London, International Planned Parenthood Federation, 1997. 387 p.
124. EXPERT PANEL ON EMERGENCY CONTRACEPTION. Consensus statement on emergency contraception. Bellagio conference on emergency contraception. Bellagio, Italy, South to South Cooperation in Reproductive Health, May 15, 1995. 8 p.
125. FADEN, R.R., BEAUCHAMP, T.L., and KING, N.M. A history and theory of informed consent. New York, Oxford University Press, 1986. 389 p.
126. FAMCARE. Retailer's contraceptive training manual for Liberia. Monrovia, Liberia, Famcare, 1988. 74 p.
127. FAMILY PLANNING LOGISTICS MANAGEMENT and JOHN SNOW INC (JSI). Programs that deliver: Logistics' contributions to better health in developing countries. [report]. Arlington, Virginia, JSI, 2000. 117 p.
128. FAMILY PLANNING SERVICE EXPANSION AND TECHNICAL SUPPORT (SEATS) PROJECT. Vital connections: Linking women's literacy programs and reproductive health services. Arlington, Virginia, John Snow, Inc, World Education, Inc, Jul. 1999. 50 p.
129. FATHALLA, M.F. Family planning linked to an obstetric service. Tropical Doctor 18(1): 25-29. Jan. 1988.
130. FATHALLA, M.F. A woman-centered agenda for the twenty-first century. Advances in Contraception 12(4): 331-334. Dec. 1996.
131. FEDERATION OF FAMILY PLANNING ASSOCIATIONS OF MALAYSIA. Family planning and sexual and reproductive health programs. <http://www.ffpam.org.my/programs.htm> Mar. 12, 2001.
132. FEELEY, F. Conducting regulatory assessments for commercial sector family planning. A summary. Arlington, Virginia, Deloitte Touche Tohmatsu International, Promoting Financial Investments and Transfers to Involve the Commercial Sector in Family Planning, 1997. 4 p.
133. FERREROS, C., CLEMENTE, W., and LEMOS FERNANDES, M.E. The impact of social marketing on the condom market in Brazil. Proceedings of the Third USAID HIV/AIDS Prevention Conference, Washington, D.C., Aug. 7-9, 1995. p. 9
134. FIGUEROA, B. Adding color to life: Illustrated health materials for women in Peru. New York, Population Council, 1992. (Quality/Calidad/Qualite No. 4) p. 13-18.
135. FINGER, W.R. Commercial sector can improve access. Network 18(2): 12-15. Research Triangle Park, North Carolina, Family Health International. Winter 1998.
136. FINGER, W.R. and KHALAF, S.G. Contraceptive methods for young adults. [Chart]. Network 17(3): 16-17. Research Triangle Park, North Carolina, Family Health International. Spring 1997.
137. FOGARTY, J.S. Reactance theory and patient noncompliance. Social Science and Medicine 45(8): 1277-1288. Oct. 1997.
138. FONTAINE, A., POTTER, L., and VENEY, J.E. Use-effectiveness of oral contraceptives and quality of care. Apr. 25, 1993. 28 p. (Unpublished)
*139. FOSTER, P. and HUDSON, S. From compliance to concordance: A challenge for contraceptive prescribers. Health Care Analysis 6(2): 123-130. Jun. 1998.
140. FRANK, M.L., POINDEXTER, A.N., JOHNSON, M.L., and BATEMAN, L. Characteristics and attitudes of early contraceptive implant acceptors in Texas. Family Planning Perspectives 24(5): 208-213. Sep./Oct. 1992.
141. FRASER, I.S., TIITINEN, A., AFFANDI, B., BRACHE, V., CROXATTO, H.B., DIAZ, S., GINSBURG, J., GU, S., HOLMA, P., and JOHANSSON, E. Norplant consensus statement and background review. Contraception 57(1): 1-9. Jan. 1998.
142. FREEDMAN, L.P. and ISAACS, S.L. Human rights and reproductive choice. Studies in Family Planning 24(1): 18-30. Jan./Feb. 1993.
143. FREEDMAN, R. Do family planning programs affect fertility preferences? A literature review. Studies In Family Planning 28(1): 1-13. Mar. 1997.
144. FREEMAN, M.A. Measuring equality: A comparative perspective on women's legal capacity and constitutional rights in five commonwealth countries. Berkeley Women's Law Journal 5: 110-138. 1989-1990.
145. FRIEDMAN, I. Poverty, human rights, and health. In: Crisp, N. and Ntuli, A., eds. South African Health Review. 5th ed. Durban, South Africa, Health Systems Trust, 1999. 12 p. (Available: <http://www.hst.org.za/sahr/99/chap1.htm>, Accessed Apr. 9, 2001)
146. FROSCH, D.L. and KAPLAN, R.M. Shared decision making in clinical medicine: Past research and future directions. American Journal of Preventive Medicine 17(4): 285-294. Nov. 1999.
147. FUTURES GROUP INTERNATIONAL. Pharmacist's contraceptive training manual. Ghana Social Marketing Programme. 1992. 85 p. (Unpublished)
148. FUTURES GROUP INTERNATIONAL and SOCIAL MARKETING FOR CHANGE (SOMARC). Ghana Social Marketing Program tracking survey 1988: Report and analysis. Washington, D.C., SOMARC, Nov. 1989. 130 p.
149. GAFNI, A., CHARLES, C., and WHELAN, T. The physician-patient encounter: The physician as a perfect agent for the patient versus the informed treatment decision-making model. Social Science and Medicine 47(3): 347-354. 1998.
150. GALLEN, M., LETTENMAIER, C., and GREEN, C.P. Counseling makes a difference. Population Reports, Series J, No. 35, Baltimore. Johns Hopkins School of Public Health, Population Information Program, Nov. 1987. p. 31.
151. GALWAY, K. and STOVER, J. Determining an appropriate contraceptive method mix. OPTIONS II tool: Policy and programmatic use of DHS data analysis chapter. [Draft]. May 4, 1994. 79 p. (Unpublished)
152. GANDOTRA, M.M. and DAS, N.P. Contraceptive choice, shift, and use continuation: A prospective study in Gujarat. Journal of Family Welfare 36(3): 54-69. Sep. 1990.
153. GANDOTRA, M.M. and DAS, N.P. Factors influencing choice of a contraceptive and the reasons for its discontinuation. In: Khan, M.E. and Cernada, G. Spacing as an Alternative Strategy. India's Family Welfare Programme. Delhi, India, B.R. Publishing Corporation, 1996. p. 95-114.
154. GARATE, M.R., MOSTAJO, P., ROSEN, J.E., and ROJO, M. CBD promoter incentives for IUD insertion referral: Can they lead to client coercion and abuse? Findings from Peru. Proceedings of the 119th Annual Meeting of the American Public Health Association, Atlanta, Georgia, Nov. 11-14, 1991. 17 p. (Unpublished)
155. GARDNER, R., BLACKBURN, R.D., and UPADHYAY, U.D. Closing the condom gap. Population Reports, Series H, No. 9. Baltimore, Johns Hopkins School of Public Health, Population Information Program, April 1999. 36 p.
156. GAWANDE, A. Whose body is it, anyway? What doctors should do when patients make bad decisions. Annals of Medicine, The New Yorker, Oct. 4, 1999. p. 84-91.
157. GAY, J. A literature review of the client-provider interface in maternal and child health and family planning clinics in Latin America. Washington, D.C., Pan American Health Organization, Nov. 1980. 78 p.
158. GAZIANO, C. The knowledge gap: An analytical review of media effects. Communication Research 10(4): 447-486. Oct. 1983.
159. GEARY, J. From comparison to choices. The voice of the voiceless. ORGYN (4): 10-13. 1994.
160. GEORGETOWN UNIVERSITY. Deciding whether to use natural family planning: The couple decision-making process. Georgetown University, Mar. 30, 2000. p. 1-17.
161. GERMAN MINISTRY OF COOPERATION AND DEVELOPMENT (BMZ). BMZ aktuell. Sector Policy. Bonn, Germany, BMZ, Jun. 1991. 24 p.
162. GERTNER, N. Interference with reproductive choice. In: Cohen, S. and Taub, N. Reproductive Laws for the 1990s. Contemporary Issues in Biomedicine, Ethics, and Society. Clifton, New Jersey, Humana Press, 1989. p. 307-328.
163. GODLEY, J. Kinship networks and contraceptive choice in Nang Rong, Thailand. International Family Planning Perspectives 27(1): 4-10, 41. Mar. 2001. (Available: <http://www.agi-usa.org/journals/toc/ifpp2701toc.html>, Accessed Mar. 22, 2001)
164. GOODKIND, D. and PHAN, T.A. Reasons for rising condom use in Vietnam. International Family Planning Perspectives 23(4): 173-178. Dec. 1997.
165. GRADY, W.R., HAYWARD, M.D., BILLY, J.O., and FLOREY, F.A. Contraceptive switching among currently married women in the United States. Journal of Biosocial Science (11 Suppl.): S117-132. 1989.
166. GRAY, A., CHOWDHURY, J.H., CALDWELL, B., and AL-SABIR, A. "Traditional" family planning in Bangladesh. Summary report. Dhaka, Bangladesh, Population Council, 1997. 41 p.
167. GREADY, M., KLUGMAN, B., XABA, M., BOIKANYO, E., and REES, H. South African women's experiences of contraception and contraceptive services. In: Ravindran, S.T.K., Berer, M., and Cottingham, J., eds. Beyond Acceptability: Users' Perspectives on Contraception. London, World Health Organization. Reproductive Health Matters, 1997. p. 23-35. (Available: <http://www.who.int/reproductive-health/publications/beyond_acceptability_users_perspectives_on_contraception/beyond_acceptability_abstract.en.html>, Accessed Apr. 6, 2001)
168. GREENFIELD, S., KAPLAN, S.H., WARE, J.E., JR., MARTIN YANO, E., and FRANK, H.J.L. Patients' participation in medical care: Effects on blood sugar control and quality of life in diabetes. Journal of General Internal Medicine 3(5): 448-457. Sep./Oct. 1988.
169. GREENSPAN, A. Adding choice to the contraceptive mix: Lessons from Indonesia. Asia-Pacific Population and Policy (19): 1-4. Dec. 1991.
170. GREENWELL, K.F. Contraceptive method mix menu: Providing healthy choices for women. World Health Statistics Quarterly 49(2): 88-93. 1996.
171. GUADAGNOLI, E. and WARD, P. Patient participation in decision-making. Social Science and Medicine 47(3): 329-339. Aug. 1998.
172. GUZMAN GARCIA, S., SNOW, R., and AITKEN, I. Preferences for contraceptive attributes: Voices of women in Ciudad Juarez, Mexico. International Family Planning Perspectives 23(2): 52-58. Jun. 1997.
173. HALL, J.A., ROTER, D.L., and KATZ, N.R. Meta-analysis of correlates of provider behavior in medical encounters. Medical Care 26(7): 657-675. Jul. 1988.
174. HAQUE, I., KANE, T.T., ROY, N.C., MOZUMDER, K.A., and KHUDA, B.E. Contraceptive switching patterns in rural Bangladesh. In: Kane, T.T. and Phillips, J.F. Reproductive Health in Rural Bangladesh: Policy and Programmatic Implications. Vol. 1. Dhaka, Bangladesh, International Centre for Diarrhoeal Disease Research Bangladesh, Jul. 1997. p. 217-246.
175. HARDEE, K., AGARWAL, K., LUKE, N., WILSON, E., PENDZICH, M., FARRELL, M., and CROSS, H. Post-Cairo reproductive health policies and programs: A comparative study of eight countries. Futures Group International, POLICY Project, 1998. 69 p.
176. HARDEE, K., CLYDE, M., MCDONALD, O.P., BAILEY, W., and VILLINSKI, M.T. Assessing family planning service-delivery practices: The case of private physicians in Jamaica. Studies in Family Planning 26(6): 338-349. Nov./Dec. 1995.
177. HARDEE, K., JANOWITZ, B., STANBACK, J., and VILLINSKI, M.T. What have we learned from studying changes in service guidelines and practices? International Family Planning Perspectives 24(2): 84-90. Jun. 1998.
178. HARDON, A. Reproductive rights in practice: A comparative assessment of quality of care. In: Hardon, A. and Hayes, E. Reproductive Rights in Practice: A Feminist Report on Quality of Care. London, Zed Books, 1997. p. 193-222.
179. HARDON, A. Reviewing quality of care policies. In: Hardon, A., Mutua, A., Kabir, S., and Engelkes, E., eds. Monitoring Family Planning and Reproductive Rights. London, Zed Books, 1997. p. 23-30
180. HARDY, E., BAHAMONDES, L., OSIS, M.J., COSTA, R.G., and FAÚNDES, A. Risk factors for tubal sterilization regret, detectable before surgery. Contraception 54(3): 159-162. Sep. 1996.
181. HARDY, E., GOODSON, P., DE SOUZA, T.R., and RODRIGUEZ, C.M. Factors associated with the acceptance of Norplant or IUD among women with similar socio-demographic characteristics. Advances in Contraception 7(1): 95-105. Mar. 1991.
182. HATCHER, R.A., RINEHART, W., BLACKBURN, R., GELLER, J.S., and SHELTON, J.D. The essentials of contraceptive technology. Baltimore, Johns Hopkins School of Public Health, Population Information Program, Jul. 1997. 340 p.
183. HATCHER, R.A., TRUSSELL, J., STEWART, F., CATES, W., STEWART, G.K., GUEST, F., and KOWAL, D. Contraceptive technology. 17th ed. New York, Irvington Publishers, Inc., 1998.
184. HAWS, J.M., BUTTA, P.G., and GIRVIN, S. A comprehensive and efficient process for counseling patients desiring sterilization. Nurse Practitioner 22(6): 52, 55-56, 59-61. Jun. 1997.
185. HEICHELHEIM, J., HOLSCHER, M., MEEKERS, D., and

PIRVULESCU, M. Pharmacist survey of contraceptive availability, knowledge and practices, Romania. Bucharest, Romania, Population Services International, 1998. 43 p.

186. HEISE, L., ELLSBERG, M., and GOTTEMOELLER, M. Ending violence against women. Population Reports, Series L, No. 11, Baltimore. Johns Hopkins School of Public Health, Population Information Program, Sept. 1999. 44 p.

*187. HEISE, L.L. Beyond acceptability: Reorienting research on contraceptive choice. In: Ravindran, S.T.K., Berer, M., and Cottingham, J., eds. Beyond Acceptability: Users Perspectives on Contraception. Geneva, World Health Organization, Reproductive Health Matters, 1997. p. 6-14.

188. HODGINS, S.R. Contraceptive discontinuation in Togo and women's experience with method use and services. Dissertation, Department of Health Behavior and Health Education, University of North Carolina at Chapel Hill School of Public Health, Chapel Hill, North Carolina, 2000. 233 p.

189. HOLDEN, C. "Right-to-life" scores new victory at AID. Science 229(4718): 1065-1067. Sep. 13, 1985.

190. HOLLERBACH, P.E. Factors that determine the appropriateness of new technologies to consumer needs. New York, Population Council, Center for Policy Studies, 1982. (Working Papers No. 94) 65 p.

191. HUBACHER, D., GOCO, N., GONZALEZ, B., and TAYLOR, D. Factors affecting continuation rates of DMPA. Contraception 60(6): 345-351. Dec. 1999.

192. HUEZO, C. and BRITTON, A. [IPPF's official policy on informed choice of contraception] Personal communication, Jan. 29, 2001.

*193. HUEZO, C. and MALHOTRA, U. Choice and use-continuation of methods of contraception: A multicentre study. London, International Planned Parenthood Federation, 1993. 176 p.

194. HULL, T.H. The challenge of contraceptive implant removals in East Nusa Tenggara, Indonesia. International Family Planning Perspectives 24(4): 176-179. Dec. 1998. (Available: <http://www.agi-usa.org/pubs/journals/2417698.html>)

195. HUNTINGTON, D., LETTENMAIER, C., and OBENG-QUAIDOO, I. User's perspective of counseling training in Ghana: The "mystery client" trial. Studies in Family Planning 21(3): 171-177. May/Jun. 1990.

196. INSTITUTE FOR REPRODUCTIVE HEALTH (IRH). GEORGETOWN UNIVERSITY MEDICAL CENTER. Research up-date: Testing approaches to improve reproductive health knowledge, attitudes and skills. Washington, D.C., IRH, Aug. 25, 1999.

197. INTERNATIONAL CENTRE FOR DIARRHOEAL DISEASE RESEARCH BANGLADESH (ICDDR) and MATERNAL AND CHILD HEALTH FAMILY PLANNING (MCH-FP) EXTENSION PROJECT. The Matlab Project: Lessons for policy. Dhaka, Bangladesh, ICDDR, MCH-FP Extension Project, Dec. 1987. (MCH-FP Extension Project Briefing Paper No. 1) 5 p.

198. INTERNATIONAL FEDERATION OF GYNECOLOGY AND OBSTETRICS (FIGO) and FIGO COMMITTEE FOR THE STUDY OF ETHICAL ASPECT OF HUMAN REPRODUCTION. Ethical framework for gynecologic and obstetric care. Recommendations on ethical issues in obstetrics and gynecology. London, FIGO, 1997. 9 p.

199. INTERNATIONAL INSTITUTE FOR POPULATION SCIENCES (IIPS) and MACRO INTERNATIONAL INC. National Family Health Survey (NFHS-2), 1998-1999: India. Mumbai, India, IIPS, 2000. 443 p.

200. INTERNATIONAL MEDICAL STATISTICS (IMS) HEALTH. Pharmaceutical Index 1997-2000. Hormonal contraceptive Egypt market study. Cham, Switzerland, IMS Health, 2000.

201. INTERNATIONAL PLANNED PARENTHOOD FEDERATION (IPPF). Effect of counselling on use-continuation of contraception. Highlights from an IPPF study. IPPF Medical Bulletin 27(6): 3-4. Dec. 1993.

202. INTERNATIONAL PLANNED PARENTHOOD FEDERATION (IPPF). IPPF Charter on sexual and reproductive rights. London, IPPF, 1996. 63 p.

203. INTERNATIONAL PLANNED PARENTHOOD FEDERATION (IPPF) and INTERNATIONAL MEDICAL ADVISORY PANEL. Statement on dual protection against unwanted pregnancy and sexually transmitted infections, including HIV. London, IPPF, May 2000. 3 p.

204. INTERNATIONAL PLANNED PARENTHOOD FEDERATION (IPPF) and WORKING GROUP ON THE PROMOTION OF FAMILY PLANNING AS A BASIC HUMAN RIGHT. The human right to family planning. November 1983. London, IPPF, 1984. 52 p.

205. IRELAND. Health, Family Planning Amendment Act, 1992. Oireachtas (20): 1-9. Dublin, Ireland, Jul. 1992.

206. IRWANTO, PRASADJA, H., SUNARNO, N., POERWANDARI, E.K., HARDEE, K., EGGLESTON, E., and HULL, T. In the shadow of men: Reproductive decision-making and women's psychological well-being in Indonesia. Research Triangle Park, North Carolina, Women's Studies Project, Family Health International, Dec. 1997. 69 p. (Available: <http://www.fhi.org/en/wsp/wsfinal/pfds/indo4.pdf>, Accessed Mar. 28, 2001)

207. ISAACS, S.L. Incentives, population policy, and reproductive rights: Ethical issues. Studies in Family Planning 26(6): 363-367. Nov./Dec. 1995.

208. ISLAM, N.M. and RAHMAN, M.M. Client satisfaction with sterlization procedure in Bangladesh. Asia-Pacific Population Journal 8(1): 39-52. Mar. 1993.

209. JACOBSON, J.L. Transforming family planning programmes: Towards a framework for advancing the reproductive rights agenda. Reproductive Health Matters 8(15): 21-32. May 2000.

210. JAFFE, F.S. Commentary: Some policy and program implications of "Contraceptive Failure in the United States". Family Planning Perspectives 5(3): 143-144. Summer 1973.

211. JAIN, A. Walking the walk: Reproductive health and family planning programs. Proceedings of the Cooperating Agencies Meeting on Reproductive Health Approach to Family Planning, Washington, D.C., Feb. 25, 1994. Population Council, p. 78-89.

*212. JAIN, A. Should eliminating unmet need for contraception continue to be a program priority? International Family Planning Perspectives 25 (Suppl.): S39-43, S49. Jan. 1999.

213. JAIN, A. Reproductive health approach to family planning: Implications for evaluating its impact. Presented at the Annual Meeting of the Population Association of America, Los Angeles, Mar. 23-25, 2000. Population Council, p. 23.

214. JAIN, A. and BRUCE, J. A reproductive health approach to the objectives and assessment of family planning programs. In: Sen, G., Germain, A., and Chen, L.C. Population Policies Reconsidered: Health, Empowerment and Rights. Boston, Harvard University Press, Mar. 1994. p. 194-209.

215. JAIN, A.K. Fertility reduction and the quality of family planning services. Studies in Family Planning 20(1): 1-16. Jan./Feb. 1989.

216. JANOWITZ, B., CHEGE, J., THOMPSON, A., RUTENBERG, N., and HOMAN, R. Community-based distribution in Tanzania: Costs and impacts of alternative strategies to improve worker performance. International Family Planning Perspectives 26(4): 158-160, 193-195. Dec. 2000. (Available: <http://www.agi-usa.org/pubs/journals/2615800.html>, Accessed Apr. 2, 2001)

217. JANOWITZ, B., HOLTMAN, M., HUBACHER, D., and JAMIL, K. Can the Bangladeshi family planning program meet rising needs without raising costs? International Family Planning Perspectives 23(3): 116-121, 145. Sep. 1997. (Available: <http://www.agi-usa.org/pubs/journals/2311697.html>, Accessed Apr. 2, 2001)

218. JEJEEBHOY, S. Women's education, autonomy, and reproductive behaviour: Experience from developing countries. Oxford, Clarendon Press, 1996. 328 p.

219. JEJEEBHOY, S.J. The importance of social science research in protecting adolescents' sexual and reproductive choice. Medicine and Law 18(2-3): 255-275. 1999.

220. JENNINGS, V., MURPHY, E., STEELE, C., EISEMAN, E., HUBER, S.C., LION-COLEMAN, A., RUDY, S., and WILSON, A. Creating the organizational context for positive client-provider interaction: A leadership challenge. Washington, D.C., United States Agency for International Development, 1999. (MAQ Papers No. 1) 18 p.

221. JIMENEZ, E. Pricing policy in the social sectors: Cost recovery for education and health in developing countries. Baltimore, The Johns Hopkins University Press. 1987.

222. JOHNS HOPKINS PROGRAM FOR INTERNATIONAL TRAINING IN REPRODUCTIVE HEALTH (JHPIEGO). Performance improvement process. <http://www.reproline. jhu.edu/english/3improve/3process/3pi.htm> JHPIEGO, Jan. 20, 1999.

223. JOHNS HOPKINS SCHOOL OF PUBLIC HEALTH CENTER FOR COMMUNICATION PROGRAMS (JHU/CCP). Distance education works: Improving quality of care by stimulating client demand and provider skills. [Project Summary]. Baltimore, JHU/CCP, Jan. 1998. (Communication Impact No. 1) 2 p.

224. JONES, B.S. Emergency contraceptive pills: What does the law say about prescribing, dispensing, repackaging, and advertising? Journal of the American Medical Women's Association 53(5 Suppl. 2): S233-237. 1998.

225. KABIR, S. (Population Concern) [Payments in Bangladesh] Personal communication, March 12, 2001.

226. KABIR, S.M. and CHAKLADER, H. Contraceptives at your doorstep: Two urban and two rural areas of Bangladesh. In: Hardon, A. and Hayes, E. Reproductive Rights in Practice: A Feminist Report on Quality of Care. London, Zed Books, 1997. p. 112-132.

227. KAK, N., THOMAS, M., and UNDERWOOD, C. Research findings of the Private Sector Initiatives Subproject POP/FP III Project. [Draft]. Baltimore, Johns Hopkins University, Population Communication Services, Sep. 15, 1998. 84 p.

228. KALMUSS, D., DAVIDSON, A., CUSHMAN, L., HEARTWELL, S., and RULIN, M. Potential barriers to the removal of Norplant among family planning clinic patients. American Journal of Public Health 88(12): 1846-1849. Dec. 1998.

229. KANE, T.T., GAMINIRATNE, K.H., and E.H., S. Contraceptive method switching in Sri Lanka: Patterns and implications. International Family Planning Perspectives 14(2): 68-75. Jun. 1988.

230. KAPLAN, S.H. and WARE , J.E., JR. The patient's role in health care and quality assessment. In: Goldfield, N. and Nash, D.B., eds. Providing Quality Care. Future Challenges. 2nd ed. Ann Arbor, Michigan, Health Administration Press, 1995. p. 25-52.

231. KATZ, J. Reflections on informed consent: 40 years after its birth. Journal of American College of Surgeons 186(4): 466-474. Apr. 1998.

232. KAZI, S. and SATHAR, Z.A. Productive and reproductive choices: Report of a pilot survey of urban working women in Karachi. Pakistan Development Review 25(4): 593-608. Winter 1986.

233. KELLER, A., VILLARREAL, F.S., DE RODRÍGUEZ, A.R., and CORREU, S. The impact of organization of family planning clinics on waiting time. Studies in Family Planning 6(5): 134-140. 1975.

234. KELLER, S. Updating service delivery guidelines and practices: A workshop on recent recommendations and experiences, Guatemala City, March 6, 1995. Research Triangle Park, North Carolina, Family Health International, Aug. 1995.

235. KENNEDY, K.I. Post-partum contraception. Bailliere's Clinical Obstetrics and Gynaecology 10(1): 25-41. Apr. 1996.

236. KENNEY, G.M. Assessing legal and regulatory reform in family planning. Washington, D.C., Futures Group International, Jan. 1993. (OPTIONS Policy Paper No. 1) 28 p.

237. KENYA GUIDELINES UPDATE EVALUATION STUDY GROUP. The effectiveness of national dissemination of updated reproductive health/family planning guidelines in Kenya. [Draft final report]. Nairobi, Kenya Guidelines Update Evaluation Study Group, Feb. 7, 2001. 20 p.

238. KHALIFA, M.A. Determinants of the choice of source for family planning services in Egypt. Presented at the Cairo Demographic Center (CDC) 23rd Annual Seminar on Population and Development Issues in the Middle East, Africa, and Asia, Cairo, Dec. 12-14, 1993. p. 26 (Unpublished)

239. KHALIL, K. and MYNTTI, C. Target-setting in family planning programs: Issues and controversies. Presented at the Population Council Symposium on Family, Gender, and Population Policy, Cairo, Feb. 7-9, 1994. p. 18 (Unpublished)

240. KHAN, A.R., BOON-ANN, T., and MEHTA, S. Quality of care and target-free approach for family planning programmes. United Nations Economic and Social Commission for Asia and the Pacific, Population Programme, Oct. 4, 1999. 17 p.

241. KHAN, J.R., THAPA, S., and GAMINIRATNE, K.H. Sociodemographic determinants of contraceptive method choice in Sri Lanka: 1975-1982. In: Tsui, A.O. and Herbertson, M.A. Dynamics of Contraceptive Use. Cambridge, England, Parkes Foundation, 1989. p. 41-60.

242. KIM, Y.M. Differences in counseling men and women: Family planning in Kenya. Patient Education and Counseling 39(1): 37-47. Jan. 2000.

243. KIM, Y.M., KOLS, A., BONNIN, C., RICHARDSON, P., and ROTER, D. Client communication behaviors with health care providers in Indonesia. [Draft]. Baltimore, Johns Hopkins School of Public Health, Center for Communication Programs, Aug. 25, 2000. 30 p.

*244. KIM, Y.M., KOLS, A., and MUCHEKE, S. Informed choice and decision-making in family planning counseling in Kenya. International Family Planning Perspectives 24(1): 4-11, 42. Mar. 1998.

*245. KIM, Y.M., KOLS, A., THUO, M., MUCHEKE, S., and ODALLO, D. Client-provider communication in family planning: Assessing audiotaped consultations from Kenya. Baltimore, Johns Hopkins School of Public Health, Center for Communication Programs, Jan. 1998. (Working Paper No. 5) 63 p. (Available: <http://www.jhuccp.org/pubs/working_papers/wp5/>)

246. KIM, Y.M., LETTENMAIER, C., ODALLO, D., THUO, M., and KHASIANI, S. Haki Yako: A client-provider information, education, and communication project in Kenya. Baltimore, Johns Hopkins University, Center for Communication Programs, Dec. 1996. (IEC Field Report No. 8) 39 p.

247. KIM, Y.M., MARANGWANDA, C., and KOLS, A. Quality of counselling of young clients in Zimbabwe. East African Medical Journal 74(8): 514-518. Aug. 1997.

*248. KIM, Y.M., ODALLO, D., THUO, M., and KOLS, A. Client participation and provider communication in family planning counseling: Transcript analysis in Kenya. Health Communication 11(1): 1-19. 1999.

249. KIM, Y.M., PUTJUK, F., BASUKI, E., and KOLS, A. Self-assessment and peer review: Improving Indonesian service providers' communication with clients. International Family Planning Perspectives 26(1): 4-12. Mar. 2000.

250. KIM, Y.M., PUTJUK, F., BASUKI, E., and LEWIS, G. "Smart Patient" coaching in Indonesia: A strategy to improve client and provider communication. Presented at the SARC 2001 Meeting, Bali, Indonesia, Feb. 2001. Johns Hopkins School of Public Health, Center for Communication Programs. 28 p.

251. KING, L. "France needs children": Pronatalism, nationalism and women's equity. Sociological Quarterly 39(1): 33-52. Winter 1998.

252. KIRAGU, K., KRENN, S., KUSEMIJU, B., AJIBOYE, J.K.T., CHIDI, I., and KALU, O. Promoting family planning through mass media in Nigeria: Campaigns using public service announcements and a national logo. Baltimore, Johns Hopkins School of Public Health, Center for Communication Programs, Jul. 1996. (IEC Field Report No. 5) 5 p. (Available: <http://www.jhuccp.org/pubs/field_reports/fr5/contents.html>, Accessed Mar. 21, 2001)

253. KIRSCH, J.D. and CEDENO, M.A. Informed consent for family planning for poor women in Chiapas, Mexico. Lancet 354(9176): 419-420. Jul. 31, 1999.

254. KLEINMAN, A. Explanatory models in health-care relationships: A conceptual frame for research on family-based health-care activities in relation to folk and professional forms of clinical care. [MIT Press Series on the Humanistic and Social Dimensions of Medicine No. 5]. In: Stoeckle, J.D. Encounters Between Patients and Doctors: An Anthology. Cambridge, Massachusetts, MIT Press, 1987. p. 273-283.

255. KOENIG, M.A., FOO, G.H., and JOSHI, K. Quality of care within the Indian Family Welfare Programme: A review of recent evidence. Studies in Family Planning 31(1): 1-18. Mar. 2000.

256. KOLS, A. and SHERMAN, J.E. Family planning programs: Improving quality. Population Reports, Series J, No. 47, Baltimore. Johns Hopkins School of Public Health, Population Information Program, Nov. 1998. 40 p.

257. KONATE, D.L. and CASTLE, S. The impact of family planning on the lives of women in the district of Bamako, Mali: Interim report after third round of interviews. Research

Triangle Park, North Carolina, Family Health International, 1999.
258. KOST, J., FORREST, J.D., and HARLAP, S. Comparing the health risks and benefits of contraceptive choices. Family Planning Perspectives 23(2): 54-61. Mar./Apr. 1991.
259. KUMAR, J. Making informed choice real in service delivery. Presented at the AID/CA's Meeting on Informed Choice and Tiahrt Amendment, Washington, D.C., Sep. 5, 2000. AVSC International. 4 p.
260. KUMAR, J. (AVSC International) [Donor Requirements] Personal communication, Jan. 12, 2001.
261. KUMAR, S. Health-care camps for the poor provide mass sterilisation quota. Lancet 353(9160): 1251. Apr. 10, 1999.
262. LADJALI, M. Conception, contraception: Do Algerian women really have a choice? In: Turshen, M. Women and Health in Africa. Trenton, New Jersey, Africa World Press, 1991. p. 125-141.
263. LAMBERT, W. and SIDOTI, N. Choosing instructional languages for educational radio broadcasts in less developed countries. (World Bank Staff Working Paper No. 491) In: Feliciano, G., Hancock, A., Hein, G., Horley, A., Jenkins, J., Lambert, W., Perraton, H., Sakamoto, T., Sidoti, N., and Tiffin, J. Futagami, S., ed. The Educational Uses of Mass Media. Washington, D.C., World Bank, 1981. p. 74-93.
264. L'ANCIEN, A. The earthquake at Karlsruhe: Germany finally wakes up to the fact of its decline? Population et Avenir (641): 6-8. Jan./Feb. 1999.
265. LASEE, A. and BECKER, S. Husband-wife communication about family planning and contraceptive use in Kenya. International Family Planning Perspectives 23(1): 15-20, 33. Mar. 1997.
266. LAZCANO PONCE, E.C., SLOAN, N.L., WINIKOFF, B., LANGER, A., COGGINS, C., HEIMBURGER, A., CONDE-GLEZ, C.J., and SALMERON, J. The power of information and contraceptive choice in a family planning setting in Mexico. Sexually Transmitted Infections 76(4): 277-281. Aug. 2000. (Available: <www.sextransinf.com>)
267. LEI, Z.W., WU, S.C., GARCEAU, R.J., S JIANG, S., YANG, Q.Z., WANG, W.L., and VANDER MEULEN, T.C. Effect of pretreatment counseling on discontinuation rates in Chinese women given depo-medroxyprogesterone acetate for contraception. Contraception 53(6): 357-361. Jun. 1996.
268. LEÓN, F.R., MONGE, R., ZUMARÁN, A., GARCÍA, I., and RÍOS, A. Length of counseling sessions and the amount of relevant information exchanged: A study in Peruvian clinics. International Family Planning Perspectives 27(1): 28-33, 46. Mar. 2001. (Available: <http://www.agi-usa.org/pubs/journals/2702801.html>)
269. LEONARD, A.H. and LADIPO, O.A. Post-abortion family planning: Factors in individual choice of contraceptive methods. Advances in Abortion Care 4(2): 1-4. Carrboro, North Carolina, IPAS. 1994.
270. LEOPRAPAI, B. Role of private sector in family planning service delivery. Journal of Population and Social Studies 7(2): 11-17. Jan. 1999.
271. LLOYD, C. Family and gender issues for population policy. New York, Population Council, 1993. (Working Paper No. 48) 41 p.
272. LOWES, R. Patient-centered care for better patient adherence. Family Practice Management 5(3): 46-47, 51-54, 57. Mar. 1998. (Available: <http://www.aafp.org/fpm/980300fm/patient.html>, Accessed Mar. 28, 2001)
273. LUNDGREN, R., PAVON, S., and REYES, O. Informed choice. Presented at the Annual Conference of the American Public Health Association, Boston, 2000. ASHONPLAFA, Honduran Ministry of Health, Institute for Reproductive Health, Georgetown University, p. 27.
274. LUOMA, M. and BEASLEY, D. Performance improvement: Helping workers do their best. PRIME Series 1(1): 6. Chapel Hill, North Carolina, University of North Carolina at Chapel Hill, School of Medicine, Program for International Training in Health, PRIME Project, 1999.
275. LUTZ, W. Future reproductive behavior in industrialized countries. In: Lutz, W. The Future Population of the World. Laxenburg, Austria, International Institute for Applied Systems Analysis, 1994. p. 267-294.
276. MAGNANI, R.J., HOTCHKISS, D.R., FLORENCE, C.S., and SHAFER, L.A. The impact of family planning supply environment on contraceptive intentions and use in Morocco. Studies in Family Planning 30(2): 120-132. Jun. 1999.
277. MANTELL, J. Family planning clinics. New York, New York State Psychiatric Institute, Columbia University, 2001.
278. MAQ EXCHANGE. Maximizing Access and Quality (MAQ) Exchange Facilitator Notebook. Washington, D.C., United States Agency for International Development, 2000. 103 p.
279. MARSHALL, M., JENNINGS, V., and CACHAN, J. Reproductive health awareness: An integrated approach to obtaining a high quality of health. Advances in Contraception 13(2-3): 313-318. Jun./Sep. 1997.
280. MATHIS, J. Status of national FP/RH guidelines. Washington, D.C., United States Agency for International Development, May 12-13, 1998.
281. MATTESON, P.S. and HAWKINS, J.W. Women's patterns of contraceptive use. Health Care for Women International 18(5): 455-466. Sep./Oct. 1997.
282. MCCAULEY, A.P. and GELLER, J.S. Decisions for Norplant programs. Population Reports, Series K, No. 4, Baltimore. Johns Hopkins School of Public Health, Population Information Program, Nov. 1992. 32 p.
283. MCCAULEY, A.P., ROBEY, B., BLANC, A.K., and GELLER, J.S. Opportunities for women through reproductive choice. Population Reports, Series M, No. 12, Baltimore. Johns Hopkins School of Public Health, Population Information Program, Jul. 1994. 40 p.
284. MCINTOSH, N. and OLIVERAS, E., eds. Service delivery guidelines for family planning programs. Baltimore, Johns Hopkins Program for International Education in Reproductive Health, 1996. 113 p.
285. MCKINSTRY, B. Do patients wish to be involved in decision making in the consultation? A cross sectional survey with video vignettes. British Medical Journal 321: 867-871. Oct. 7, 2000.
286. MEASURE EVALUATION. Short list of QC indicators matched with QC instruments. Chapel Hill, North Carolina, MEASURE Evaluation, Carolina Population Center, University of North Carolina at Chapel Hill, Oct. 19, 1999. 2 p.
287. MILLER, E.R., SHANE, B., and MURPHY, E. Contraceptive safety: Rumors and realities. Washington, D.C., Dec. 1998. 40 p.
288. MILLER, K., MILLER, R., FASSIHIAN, G., and JONES, H. How providers restrict access to family planning methods: Results from five African countries. In: Miller, K., Miller, R., Askew, I., Horn, M.C., and Ndhlovu, L., eds. Clinic-Based Family Planning and Reproductive Health Services in Africa: Findings From Situation Analysis Studies. New York, Population Council, Nov. 1998. p. 159-179.
289. MILLER, R., ASKEW, I., HORN, M.C., and MILLER, K. Clinic-based family planning and reproductive health programs in sub-Saharan Africa. In: Miller, K., Miller, R., Askew, I., Horn, M.C., and Ndhlovu, L., eds. Clinic-Based Family Planning and Reproductive Health Services in Africa: Findings From Situation Analysis Studies. New York, Population Council, Nov. 1998. p. 245-255.
290. MILLER, W.B. and PASTA, D.J. The relative influence of husbands and wives on the choice and use of oral contraception, a diaphragm, and condoms. Journal of Applied Social Psychology 26(19): 1749-1774. Oct. 1-15, 1996.
291. MITRA, S.N. and AL-SABIR, A. Contraceptive use dynamics in Bangladesh. Calverton, Maryland, Macro International, Oct. 1996. (DHS Working Papers No. 21) 28 p.
292. MKANGI, K. The social cost of small nuclear families: A critique of demographic transition. (Occasional Papers from Summary Series B) Developmental Studies (2): 43-49. 1992.
293. MONTGOMERY, M.R. and CHUNG, W. Social networks and the diffusion of fertility control: The Korean case. Presented at the Seminar on Values and Fertility Change, sponsored by the International Union for the Scientific Study of Population, Sion, Switzerland, Feb. 16-19, 1994. 44 p. (Unpublished)
294. MOORE, K. and HELZNER, J.F. What's sex got to do with it? Challenges for incorporating sexuality into family planning programs. Presented at the Workshop on the Challenges of Incorporating Sexuality into Family Planning Programs, New York, Feb. 6, 1996. Population Council, p. 28
295. MORGAN, C. and MURGATROYD, S. Total quality management in the public sector: An international perspective. Buckingham, England, Open University Press, 1994. 200 p.
296. MOTT, F.L. and MOTT, S.H. Household fertility decisions in West Africa: A comparison of male and female survey results. Studies in Family Planning 16(2): 88-99. Mar./Apr. 1985.
297. MOULTON, J. Formal and nonformal education and empowered behavior. A literature review. Washington, D.C., Support for Analysis and Research in Africa, Academy for Educational Development, Apr. 1997. 48 p. (Available: <http://www.usaid.gov/regions/afr/hhraa/formal/full.txt>, Accessed Apr. 9, 2001)
*298. MURPHY, E. and STEELE, C. Client-provider interactions in family planning services: Guidance from research and program experience. Washington, D. C., United States Agency for International Development. Office of Population/Research Division, 2000. (MAQ Papers No. 2) 11 p.
299. MURPHY, E. and STEELE, V.C. Client Provider Interactions (CPI) in family planning services: Guidance from research and program experience. In: Technical Guidance and Competence Working Group, Program for International Training in Health, Department of Epidemiology, and University of North Carolina at Chapel Hill. Recommendations for Updating Selected Practices in Contraceptive Use. Vol. 2. 1997. p. 187-194.
300. MUTUA, A.N., ONDOLO, O., MUNANIE, E., and NDIKU, K. A wide range of methods to reduce population: Two rural regions and one urban area in Kenya. In: Hardon, A. and Hayes, E. Reproductive Rights in Practice: A Feminist Report on Quality of Care. London, Zed Books, 1997. p. 59-76.
301. NAKATO, L. Have you heard the rumour? Africa Women and Health 2(3): 23-27. Jul./Sep. 1994.
302. NATIONAL FAMILY PLANNING & REPRODUCTIVE HEALTH ASSOCIATION (NFPRHA). NFPRHA report: The pill set to become legal in Japan. <http://www.unfpa.org/swp/1999/pdf/swp99.pdf> NFPRHA, Jun. 2, 1999.
303. NDHLOVU, L., SOLO, J., MILLER, R., MILLER, K., and OMINDE, A. An assessment of clinic-based family planning services in Kenya: Results from the 1995 situation analysis study. New York, Population Council, Jan. 1997. 44 p. (Available: <http://www.popcouncil.org/pdfs/aor/ken1.pdf>, Accessed Mar. 20, 2001)
304. NEAMATALLA, G.S. and HARPER, P.B. Family planning counseling and voluntary sterilization. A guide for managers. New York, Association for Voluntary Surgical Contraception, 1990. 57 p.
305. NEAMATALLA, G.S. and STEELE VERME, C. Postabortion women: Factors influencing their family planning options. New York, AVSC International, Sep. 1995. (AVSC Working Paper No. 9) 14 p.
*306. NEW ZEALAND. DEPARTMENT OF HEALTH. Principles and guidelines for informed choice and consent. Wellington, New Zealand, Department of Health, May 1991. 8 p.
307. OBWAKA, W., RUMINJO, J.K., NDAVI, P.N., and SEKADDE-KIGONDU, C. Correlates of contraceptive failure among clients attending an antenatal clinic in Nairobi. East African Medical Journal 74(9): 561-565. Sep. 1997.
308. O'CONNOR, A.M., ROSTOM, A., FISET, V., TETROE, J., ENTWISTLE, V., LLEWELLYN-THOMAS, H., HOLMES-ROVNER, M., BARRY, M., and JONES, J. Decision aids for patients facing health treatment or screening decisions: Systematic review. British Medical Journal 319(7212): 731-734. Sep. 18, 1999.
309. OKWUDISHU, C. Patterns of ownership and accessibility to information and media facilities in democratizing the media in Nigeria. Africa Media Review 3(1): 121-133. 1988.
310. OPARA, J.U., ERNST, F.A., GASKIN, H., SMITH, L., and NEVELS, H.V. Factors associated with elective Norplant removal in black and white women. Journal of the National Medical Association 89(4): 237-240. Apr. 1997.
311. OZALP, S., YALCIN, O.T., HASSA, H., ERBAY, B., and DALAN, N. Factors affecting the contraceptive choice in a developing country. International Journal of Gynecology and Obstetrics 65(1): 53-57. Apr. 1999.
312. PALMA-SEALZA, L., COSTELLO, M.P., and ECHAVEZ, C. Male involvement through reproductive health awareness in Bukidnon Province, the Philippines: An intervention study. Manila, Population Council, Philippines Department of Health, Jun. 1998. 109 p.
313. PALMORE, J.A. Awareness sources and stages in the adoption of specific contraceptives. Demography 5(2): 960-972. 1968.
314. PANEL ON POPULATION PROJECTIONS, COMMITTEE ON POPULATION, and NATIONAL RESEARCH COUNCIL. Posttransition fertility. In: Bongaarts, J. and Bulatao, R.A. Beyond six billion: Forecasting the world's population. Washington, D.C., National Academy Press, 2000. 258 p.
315. PANOS. Women's health: Using human rights to gain reproductive rights. London, Panos Global Information Programmes, Dec. 1998. (Panos Briefing No. 32) 24 p.
316. PARIANI, S., HEER, D.M., and VAN ARSDOL, M.D. Continued contraceptive use in five family planning clinics in Surabaya, Indonesia. Presented at the 115th Annual Meeting of the American Public Health Association, New Orleans, Louisiana, Oct. 18-22, 1987. 7 p.
*317. PARIANI, S., HEER, D.M., and VAN ARSDOL, M.D. Does choice make a difference to contraceptive use? Evidence from East Java. Studies in Family Planning 22(6): 384-390. Nov./Dec. 1991.
318. PARIANI, S., HEER, D.M., VAN ARSDOL, M.D., and HAYWARD, M. Continued use of contraception among clients in East Java, Indonesia. Presented at the 117th Annual Meeting of the American Public Health Association, Chicago, Oct. 22-24, 1989. 10 p. (Unpublished)
319. PARRAS, M. and MORALES, M.J. Reproductive rights on paper: Four Bolivian cities. In: Hardon, A. and Hayes, E. Reproductive Rights in Practice: A Feminist Report on Quality of Care. London, Zed Books, 1997. p. 77-94.
320. PETCHESKY, R. and JUDD, K. Negotiating reproductive rights: Women's perspectives across countries and cultures. Atlantic Highlands, New Jersey, Zed Books, 1998. 358 p.
321. PFANNENSCHMIDT, S., MCKAY, A., and MCNEILL, E. Through a gender lens. Washington, DC, US Agency for International Development, October 1997. 44 p.
*322. PHILLIBER, S. Contraception and informed choice in the United States: A review of literature. Research Triangle Park, North Carolina, Family Health International, Jun. 1988. 49 p.
323. PHILLIPS, J.F., GREENE, W.L., and JACKSON, E.F. Lessons from community-based distribution of family planning in Africa. New York, Population Council, 1999. (Policy Research Division Working Papers No. 121) 102 p.
324. PINE, R.N. Maintaining a focus on informed choice. AVSC NEWS, Vol. 36, No. 3, New York. AVSC International, Fall 1998. p. 6, 8.
325. PIOTROW, P.T., KINCAID, D.L., RIMON II, J.G., and RINEHART, W. Health communication: Lessons from family planning and reproductive health. Westport, Connecticut, Praeger, 1997. 307 p.
326. PODHISITA, C. Gender decision making in family formation and planning: Achievement and future direction. Journal of Population and Social Studies 6(1-2): 1-27. Jan. 1998.
327. POPULATION ACTION INTERNATIONAL (PAI). Contraceptive choice: Worldwide access to family planning. 1997 report on progress towards world population stabilization. Washington, D.C., PAI, 1997. (Available: <http://www.populationaction.org/programs/rc97.htm>)
328. POPULATION COUNCIL. Secrecy and silence: Why women hide contraceptive use. Population Briefs 4(3): 3. Sep. 1998.
329. POPULATION SERVICES INTERNATIONAL (PSI). PROSALUD in Venezuela. Country fact sheet. Washington, D.C., PSI, Sep. 2000. 2 p. (Available: <http://www.psi.org/psi_ops/ cfs/47_venezuela.html>)
330. POTTER, J.E. The persistence of outmoded contraceptive regimes: The cases of Mexico and Brazil. Population and

Development Review 25(4): 703-739. Dec. 1999.
331. POTTS, M. The population policy pendulum. British Medical Journal 319(7215): 933-934. Oct. 1999.
332. POTTS, M. (University of California, Berkeley) [User fees for CBD Programs] Personal communication, Feb. 15, 2001.
333. POTTS, M. and SHOUSE, N. International aspects of ethical problems in obstetrics and gynaecology. Baillieres Best Practice Research Clinical Obstetrics and Gynaecology 13(4): 559-570. Dec. 1999.
334. PRICE, M.M. Physically, mentally disabled teens require special contraceptive care. Contraceptive Technology Update 8(12): 154-156. Dec. 1987.
335. PRICE, N. Contraceptive social marketing: Pros and cons. Reproductive Health Matters 2(3): 51-54. May 1994.
336. QUILL, T.E. and BRODY, H. Physician recommendations and patient autonomy: Finding a balance between physician power and patient choice. Annals of Internal Medicine 125(9): 763-769. Nov. 1, 1996.
337. RAHMAN, M., BARKAT E, K., KANE, T.T., and PHILLIPS, J.F. Policy impact of the project. In: Barkat-E-Khuda, Kane, T.T., and Phillips, J.F. Improving the Bangladesh Health and Family Planning Programme: Lessons Learned Through Operations Research. Dhaka, Bangladesh, International Centre for Diarrhoeal Disease Research, Bangladesh, 1997. p. 117-126.
338. RANATUNGA, N. Incentives and informed consent. In: Jayawikramarajah, P.T. and Corea, S.M. Voluntary Surgical Contraception: A Review of Progress in Sri Lanka. Proceedings of the 2nd National Conference on Voluntary Surgical Contraception, March 1-3, 1982, Colombo, Sri Lanka. Sri Lanka Association for Voluntary Surgical Contraception, 1982. p. 193-213.
339. RASTOGI, R. Provider's key role in family planning. Innovations (1): 12. Jun. 1995.
340. RATNAM, S.S. The impact of government policies on the family planning programme of the Republic of Singapore. In: Jayawikramarajah, P.T. and Corea, S.M. Voluntary Surgical Contraception: A Review of Progress in Sri Lanka. Proceedings of the 2nd National Conference on Voluntary Surgical Contraception, March 1-3, 1982, Colombo, Sri Lanka. Sri Lanka Association for Voluntary Surgical Contraception, 1982. p. 231-233.
341. RATZAN, S.C. Health literacy: Communications for the public good. Health Promotion International; 19. p. (Forthcoming)
342. REDDY, S. and VANDEMOORTELE, J. User financing of basic social services: A review of theoretical arguments and empirical evidence. New York, United Nations Childrens Fund, 1996. (UNICEF Staff Working Papers, Evaluation, Policy and Planning Series) 105 p. (Available: <http:// www.unicef.org/reseval/pdfs/Userfees.pdf>, Accessed Mar. 15, 2001)
343. REPRODUCTIVE HEALTH OUTLOOK (RHO). Family planning program issues. <http://www.rho.org/html/fp_program_issues.html> RHO, 2001.
344. REPUBLIC OF ZAMBIA. MINISTRY OF HEALTH. Family planning in reproductive health: Policy framework, strategies and guidelines. Lusaka, Republic of Zambia Ministry of Health, Mar. 1997. 116 p.
345. RETHERFORD, R. and PALMORE, J. Diffusion Processes Affecting Fertility. In: Bulatao, R., Lee, R., Hollerbach, P., Bongaarts, J. Determinants of Fertility In Developing Countries, Vol. 2. New York, Academic Press, 1983. p. 295-339.
*346. RIMAL, R.N., RATZAN, S.C., ARNTSON, P., and FREIMUTH, V.S. Reconceptualizing the "patient": Health care promotion as increasing citizens' decision-making competencies. Health Communication 9(1): 61-74. 1997.
347. RIMON, J.G. Communication impact: Philippines communication outreach accelerates family planning use in 1993-1996. Baltimore, Johns Hopkins School of Public Health, Center for Communication Programs, Aug. 1998. (No. 3) 2 p.
*348. RINEHART, W., RUDY, S., and DRENNAN, M. GATHER guide to counseling. Population Reports, Series J, No. 48, Baltimore. Johns Hopkins School of Public Health, Population Information Program, Dec. 1998. 32 p.
349. RIVERA, R. and SOLIS, J.A. Opinion: Improve family planning after pregnancy. Network 17(4): 3. Research Triangle Park, North Carolina, Family Health International. Summer 1997. (Available: <http://www.fhi.org/en/fp/fppubs/network/v174/nt1741.html>)
350. RIZVI, S.A., NAQVI, S.A., and HUSSAIN, Z. Ethical issues in male sterilization in developing countries. British Journal of Urology 76(2 Suppl.): S103-105. Nov. 1995.
351. ROBEY, B., ROSS, J., and BHUSHAN, I. Meeting unmet need: New strategies. Population Reports, Series L, No. 8, Baltimore. Johns Hopkins School of Public Health, Population Information Program, Sep. 1996. 36 p.
352. ROBEY, B. and STAUFFER, P. Helping the news media cover family planning. Population Report, Series J, No. 42. Baltimore, Johns Hopkins School of Public Health, Population Information Program, Nov. 1995. 28 p.
353. ROBINSON, E.J. and WHITFIELD, M.J. Improving the efficiency of patients' comprehension monitoring: A way of increasing patient's participation in general practice consultations. Social Science and Medicine 21(8): 915-919. 1985.
354. ROGERS, E.M. Diffusion of innovations. 1st ed. New York, Free Press, 1983.
355. ROGERS, E.M. and KINCAID, D.L. Communication networks: Toward a new paradigm for research. New York, Free Press, 1981. 386 p.
356. ROSENSTOCK, I.M. Historical origins of the Health Belief Model. Health Education Monographs 2: 328-335. 1974.
*357. ROSS, J. and STOVER, J. Effort indices for national family planning programs, 1999 cycle. Research Triangle Park, North Carolina, Futures Group International, University of North Carolina, May 2000. (MEASURE Evaluation Working Paper)
358. RUDY, S., TABBUTT-HENRY, J., SCHAEFER, L., and MCQUIDE, P. Training for Effective Client-Provider Interaction (CPI): Issues, Processes and Recommendations. May 8, 2001. 26 p. (Draft)
359. RUTENBERG, N., BIDDLECOM, A.E., and KAONA, F.A. Reproductive decision-making in the context of HIV and AIDS: A qualitative study in Ndola, Zambia. International Family Planning Perspectives 26(3): 124-130. Sep. 2000.
*360. RUTENBERG, N. and WATKINS, S.C. The buzz outside the clinics: Conversations and contraception in Nyanza province, Kenya. Studies in Family Planning 28(4): 290-307. Dec. 1997.
361. SABA, W., VALENTE, T.W., MERRITT, A.P., KINCAID, D.L., LUJAN, M., and FOREIT, J. The mass media and health beliefs: Using media campaigns to promote preventive behavior. Presented at the 121st Annual Meeting of the American Public Health Association, San Francisco, Oct. 24-28, 1993. 25 p. (Unpublished)
362. SADANA, R. and SNOW, R. Balancing effectiveness, side-effects and work: Women's perceptions and experiences with modern contraceptive technology in Cambodia. Social Science and Medicine 49(3): 343-358. Aug. 1999.
363. SADIK, N. Guidelines for UNFPA support to family planning programmes. [Memorandum]. Dec. 29, 1992. 12 p. (Unpublished)
364. SAI, F.T. Politics and ethics in family planning. Senanayake, P. and Kleinman, R.L., eds. Proceedings of the Meeting Challenges: Promoting Choices, International Planned Parenthood Federation Family Planning Congress, New Delhi, Oct. 1992. Parthenon Publishing Group, p. 365-374.
365. SALTER, C., JOHNSTON, H.B., and HENGEN, N. Care for postabortion complications: Saving women's lives. Population Reports, Series L, No. 10, Baltimore. Johns Hopkins School of Public Health, Population Information Program, Sep. 1997. 32 p.
366. SALWAY, S. How attitudes toward family planning and discussion between wives and husbands affect contraceptive use in Ghana. International Family Planning Perspectives 20(2): 44-47, 74. Jun. 1994.
367. SCHENKER, J.G. and EISENBERG, V.H. Ethical issues relating to reproduction control and women's health. International Journal of Gynecology and Obstetrics 58(1): 167-176. Jul. 1997.
368. SCHMIDT, M.A., DABBS, C., GETSON, A., HEMMER, C., JACOBSTEIN, R., JOHNSON, C., and SCHULER, S. Report of the Informed Choice Task Force of the Bureau for Science and Technology/Office of Population. Washington, D.C., U.S. Agency for International Development, Office of Population, Nov. 1987. 48 p.
369. SCHNEIDER, C.E. The practice of autonomy: Patients, doctors, and medical decisions. New York, Oxford University Press, 1998. 307 p.
370. SCHULER, S.R., CHOQUE, M.E., and RANCE, S. Misinformation, mistrust, and mistreatment: Family planning among Bolivian market women. Studies in Family Planning 25(4): 211-221. Jul./Aug. 1994.
371. SCHULER, S.R., HASHEMI, S.M., CULLUM, A., and HASSAN, M. The advent of family planning as a social norm in Bangladesh: Women's experiences. Reproductive Health Matters 4(7): 66-78. May 1996.
372. SCHULER, S.R. and HOSSAIN, Z. Family planning clinics through women's eyes and voices: A case study from rural Bangladesh. International Family Planning Perspectives 24(4): 170-175, 205. Dec. 1998.
373. SCHULER, S.R., MCINTOSH, E.N., GOLDSTEIN, M.C., and PANDE, B.R. Barriers to effective family planning in Nepal. Studies in Family Planning 16(5): 260-270. Sep./Oct. 1985.
374. SCHULTZ, D.E., MARTIN, D., and BROWN, W.P. Strategic advertising campaigns. 2nd ed. Lincolnwood, Illinois, NTC Business Books, 1987.
375. SCOTT, T. Changing the attitudes and behaviors of men through social marketing: Pakistan, Philippines and Vietnam. International Council on Management of Population Programmes, Jan. 26, 2001. Available: <http:// www.icomp.org.my/inno4/inno4c7.htm>
376. SECRETARIA DE GOBERNACION DE MEXICO. Decreto que Reforma y Adiciona el Ariculo 4º [Decree of the Reform and Addition of Article 4]. March 31, 1974. 2 p. (Available: <http://www.juridicas.unam.mx/infjur/leg/constmex/pdf/rc079.pdf>)
377. SEEWALD, R. The couple's choices. Integration (35): 6-8. Mar. 1993.
378. SEVERY, L.J. Physicians' perceptions of contraceptive methods: Cultural comparisons. In: Palmore, J.A., Ward, S.E., and Bulatao, R.A., eds. Choosing a Contraceptive. Method Choice in Asia and the United States. (Westview Special Studies in Science, Technology, and Society Series). Boulder, Colorado, Westview Press, 1989. p. 40-56.
379. SEVERY, L.J. and MCKILLOP, K. Low-income women's perceptions of family planning service alternatives. Family Planning Perspectives 22(4): 150-157, 168. Jul./Aug. 1990.
*380. SEVERY, L.J. and THAPA, S. Preferences and tolerance as determinants of contraceptive acceptability. In: Severy, L.J., ed. Advances in Population: Psychosocial Perspectives. Vol. 2. London, Jessica Kingsley Publishers, 1994. p. 119-139.
381. SHARMA, D.C. Indian state proposes third child population control policy. Lancet 356(9236): 1178. Sept. 30, 2000.
*382. SHELTON, J., DAVIS, S., and MATHIS, J. Maximizing access and quality (MAQ): Checklist for family planning service delivery, with selected linkages to reproductive health. Washington, D.C., United States Agency for International Development, 1996. 19 p.
383. SHELTON, J.D., ANGLE, M.A., and JACOBSTEIN, R.A. Medical barriers to access family planning. Lancet 340(8831): 1334-1335. Nov. 28, 1992.
384. SHEPARD, B. Feminist ethical perspectives in the international family planning field. Presented at the 116th Annual Meeting of the American Public Health Association, Boston, Nov. 13-17, 1988. 10 p. (Unpublished)
385. SHORT, S.E. and ZHAI, F. Looking locally at China's one-child policy. Studies in Family Planning 29(4): 373-387. Dec. 1998.
386. SIMMONS, R. and SIMMONS, G.B. Moving toward a higher quality of care: Challenges for management. In: Jain, A.K. Managing quality of care in population programs. West Hartford, Connecticut, Kumarian Press, 1992. p. 23-34.
387. SIMONDS, S.K. Health education as social policy. Health Education Monograph 2(1): 1-25. 1974.
388. SINDING, S.W. Women's demands and demographic goals. Planned Parenthood Challenges 1: 13-16. 1994.
389. SMITH, J. and SAFFITZ, G. The PSI story. Accomplishments and lessons learned from Egypt's Private Sector Initiative: A special initiative for the Private Commercial Sector. Baltimore, Johns Hopkins School of Public Health, Population Communication Services, Nov. 4, 2000. 30 p.
390. SMITH, J.M. and RAO, V. Market-based services: Strategic role in family planning service expansion. New York, United Nations. Population Division. Department for Economic and Social Information and Policy Analysis, 1996. p. 449-458.
391. SMITH, R.C. and HOPPE, R.B. The patient's story: Integrating the patient- and physician-centered approaches to interviewing. Annals of Internal Medicine 115(6): 470-477. Sep. 15, 1991.
392. SNOW, R., GARCIA, S., KURESHY, N., SADANA, R., SINGH, S., BECERRA-VALDIVIA, M., LANCASTER, S., MOFOKENG, M., HOFFMAN, M., and AITKEN, I. Investigating women's preferences for contraceptive technology: Focus group data from 7 countries. Nov. 1996. (Working Paper Series No. 96.05) 32 p.
*393. SNOW, R., GARCIA, S., KURESHY, N., SADANA, R., SINGH, S., BECERRA-VALDIVIA, M., LANCASTER, S., MOFOKENG, M., HOFFMAN, M., and AITKEN, I. Attributes of contraceptive technology: Women's preferences in seven countries. In: Ravindran, S.T.K., Berer, M., and Cottingham, J., eds. Beyond Acceptability: Users Perspectives on Contraception. London, World Health Organization. Reproductive Health Matters, 1997. p. 36-48. (Available: <http://www.who.int/reproductive-health/publications/ beyond_acceptability_users_perspectives_on_contraception/beyond_acceptability_abstract.en.html>, Accessed Mar. 30, 2001)
*394. SOCHA MCGEE, D. and CEGALA, D.J. Patient communication skills training for improved communication competence in the primary care medical consultation. Journal of Applied Communication Research 26(1): 412-430. 1998.
395. SOCIAL PLANNING, ANALYSIS AND ADMINISTRATION CONSULTANTS, POPULATION COUNCIL (PC), and ASIA AND NEAR EAST OPERATIONS RESEARCH AND TECHNICAL ASSISTANCE PROJECT. Profile of clients of different providers of family planning services in Egypt. Final report. Cairo, Egypt, Social Planning, Analysis and Administration Consultants. PC. Asia and Near East Operations Research and Technical Assitance Project, May 1994. 24 p.
396. SPEIZER, I.S., HOTCHKISS, D.R., MAGNANI, R.J., HUBBARD, B., and NELSON, K. Do service providers in Tanzania University restrict clients' access to contraceptive methods? International Family Planning Perspectives 26(1): 13-20, 42. Mar. 2000.
397. SPICEHANDLER, J. Norplant introduction: A management perspective. In: Segal, S.J., Tsui, A.O., and Rogers, S.M., eds. Proceedings of the Conference on Demographic and Programmatic Consequences of Contraceptive Innovations, Washington, D.C., Oct. 6-7, 1988. Plenum Press, p. 199-225.
398. SRINIVASAN, S. Has India's population policy failed? Humanscape 6(11): 37-39. Nov. 1999.
399. STANBACK, J., NUTLEY, T., J., G., and QURESHI, Z. Menstruation requirements as a barrier to contraceptive access in Kenya. East African Medical Journal 76(3): 124-126. Mar. 1999.
400. STANBACK, J., OMONDI, O., and OMUODO,-D. Why has IUD use slowed in Kenya? Part A: Qualitative assessment of IUD service delivery in Kenya. Research Triangle Park, North Carolina, Family Health International, Aug. 1995. 47 p. (Available: <http://www.fhi.org/en/fp/fpother/fctsht/fctsht9.html>)
401. STASH, S. Reasons for unmet need in Nepal: An attempt to pick up where fertility surveys leave off. Ann Arbor, Michigan, University of Michigan, Population Studies Center, 1995. 44 p. (Unpublished)
402. STECKLOV, G. Fertility implications of reduced breastfeeding by HIV/AIDS-infected mothers in developing countries. [Letter]. American Journal of Public Health 89(5): 780-781. May 1999.
403. STEELE VERME, C., HARPER, P.B., MISRA, G., and NEAMATALLA, G.S. Family planning counseling: An evolving process. International Family Planning Perspectives 19(2): 67-71. Jun. 1993.
404. STEINBOCK, B. Coercion and long-term contraceptives. Hastings Center Report 25(1 Suppl.): S19-22. Jan./Feb. 1995.
405. STEPHENSON, M. Health care: Primary health care. In:

Middleton, J., ed. Encyclopedia of Africa South of the Sahara. Vol. 2. Charles Scribner's Sons, 2001. p. 288-299. (Available: <http://www.africana.com/tt_682.htm>, Accessed Mar. 15, 2001)

406. STEVENS, J.R. and STEVENS, C.M. Introductory small cash incentives to promote child spacing in India. Studies in Family Planning 23(3): 171-186. May/Jun. 1992.

*407. SULLIVAN, T. and BERTRAND, J., eds. Monitoring quality of care in family planning: Country reports from the Quick Investigation of Quality (QIQ). (MEASURE Evaluation Technical Report, No. 5) Chapel Hill, North Carolina, MEASURE Evaluation, Carolina Population Center, University of North Carolina at Chapel Hill, Jul. 2000. 159 p.

408. TABAK, E.R. Encouraging patient question-asking: A clinical trial. Patient Education and Counseling 12(1): 37-49. Aug. 1988.

409. TABBUTT-HENRY, J. (EngenderHealth/AVSC International) [Evolution of informed choice] Personal communication, Mar. 18, 2001.

410. TALWAR, P.P. Choice, acceptance and continuation of spacing methods in India. In: Khan, M.E. and Cernada, G. Spacing as An Alternative Strategy. India's Family Welfare Programme. Delhi, India, B.R. Publishing, 1996. p. 115-142.

*411. TASK FORCE ON INFORMED CHOICE. Informed choice: Report of the Cooperating Agencies Task Force. Baltimore, The Johns Hopkins School of Public Health, Center for Communication Programs, Jul. 1989. 37 p.

412. TAVROW, P. What prevents family planning clinics in developing countries from adopting a client orientation? An exploratory study from Malawi. Sep. 28, 1999. 55 p. (Unpublished)

413. TAYLOR, T.R. Understanding the choices that patients make. Journal of the American Board of Family Practice 13(2): 124-133. 2000.

*414. TECHNICAL GUIDANCE/COMPETENCE WORKING GROUP. Recommendations for updating selected practices in contraceptive use, Vol. 2. Family Planning and Population Unit. Division of Reproductive Health. World Health Organization, Office of Population. United States Agency for International Development, Sep. 1997. 260 p. (Available: <http://www.reproline.jhu.edu/english/6read/6multi/tgwg/6tgwg.htm>, Accessed Aug. 10, 1999)

415. THAPA, S. and FRIEDMAN, M. Female sterilization in Nepal: A comparison of two types of service delivery. International Family Planning Perspectives 24(2): 78-83. Jun. 1998.

416. THOMPSON, S.C., NANNI, C., and SCHWANKOVSKY, L. Patient-oriented interventions to improve communication in a medical office visit. Health Psychology 9(4): 390-404. 1990.

417. TRIAS, M. Fees for services in PROFAMILIA, Colombia. Ashford, L.S. and Bouzidi, M., eds. Proceedings of the Seminar on Programme Sustainability through Cost Recovery, Kuala Lumpur, Malaysia, Oct. 21-25, 1991. International Planned Parenthood Federation, p. 33-35.

418. TRUSSEL, J., KOENIG, J., VAUGHAN, B., and STEWART, F. Evaluation of a media campaign to increase knowledge about emergency contraception. Presented at the PAA Annual Meeting 2001, Washington, D.C., Mar. 29 - Apr. 1, 2001. 14 p.

419. TULADHAR, J., DONALDSON, P.J., and NOBLE, J. The introduction and use of Norplant implants in Indonesia. Studies in Family Planning 29(3): 291-299. Sep. 1998.

420. TURNER, S., MAHER, E.J., YOUNG, T., YOUNG, J., and VAUGHAN HUDSON, G. What are the information priorities for cancer patients involved in treatment decisions? An experienced surrogate study in Hodgkin's disease. British Journal of Cancer 73(2): 222-227. Jan. 1996.

421. TVERSKY, A. and KAHNEMAN, D. The framing of decisions and the psychology of choice. Science 211(4481): 453-458. Jan. 30, 1981.

422. TWEEDIE, I. and OFORI, J. Reducing facility defaulting and contraceptive discontinuation: A longitudinal study of facility defaulters in Ghana. [Draft]. Baltimore, Ghana. Ministry of Health, Health Education Unit, Johns Hopkins School of Public Health, Center for Communication Programs, Apr. 1996. 38 p.

423. TWUM-BAAH, K.A. and STANBACK, J. Provider rationales for restrictive family planning service practices in Ghana. Chapel Hill, North Carolina, Ghana Statistical Service and Family Health International, Mar. 1995. 43 p.

424. UBEL, P.A. and LOEWENSTEIN, G. The role of decision analysis in informed consent: Choosing between intuition and systematicity. Social Science and Medicine 44(5): 647-656. Mar. 1997.

425. UNITED NATIONS (UN). Proclamation of Teheran. International Conference on Human Rights. Teheran, UN, May, 13 1968.

426. UNITED NATIONS (UN). Programme of Action of the International Conference on Population and Development. Cairo, UN, 1995. 115 p.

427. UNITED NATIONS POPULATION FUND (UNFPA). The state of the world population, 1994. Choices and responsibilities. New York, UNFPA, 1994. 68 p.

428. UNITED NATIONS POPULATION FUND (UNFPA). One year after Cairo: Mexico. <www.earthsummitwatch.org /cairo1/mexico.htm> Jul. 31, 2000.

429. UNITED NATIONS POPULATION FUND (UNFPA). Quality of family planning services. New York, UNFPA, 1997. (Evaluation Report No. 8) 55 p.

430. UNITED NATIONS POPULATION FUND (UNFPA). Reproductive health and reproductive rights. In: UNFPA. The State of World Population 1999: 6 Billion. A Time for Choices. New York, UNFPA, Sep. 26, 1999. p. 34-49. (Available: <http:// www.unfpa.org/swp/1999/pdf/swp99.pdf>, Accessed Mar. 15, 2001)

431. UNITED NATIONS POPULATION FUND (UNFPA). Donor support for contraceptives and logistics. New York, NY, UNFPA, 1999. 22 p. (Available: <http://www.unfpa.org/tpd/globalinitiative/pdf/donor991.pdf>, Accessed Mar. 14, 2001)

432. UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT (USAID). MAQ: From guidelines to action. Proceedings of the USAID-sponsored conference, Washington, D.C., May 12-13, 1998. USAID, 64 p.

433. UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT (USAID). Voluntary participation and informed choice in family planning. Washington, D.C., USAID. Center for Population, Health and Nutrition, Jul. 1999. (POP Briefs) 2 p. (Available: <http://www.usaid.gov /pop_health/pop/poptiahrt.htm>)

434. UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT (USAID) and BUREAU FOR PROGRAM AND POLICY COORDINATION. USAID policy paper: Population assistance. Washington, D.C., USAID, Sep. 1982. 16 p. (Available: <www.usaid.gov/pubs/ads/pps/population/population.doc>)

435. UNITED STATES CONGRESS. Foreign Assistance Act of 1961, Amendment. Title 22: Section 2151b, 1967. (Available: <http://caselaw.lp.findlaw.com/casecode/uscodes/22/chapters/32/subchapters/i/parts/i/sections/section_2151b.html>, Accessed Mar. 7, 2001)

436. UNIVERSITY OF CALIFORNIA AT BERKELEY SCHOOL OF PUBLIC HEALTH. Doctor: Can we talk? UC Berkeley Wellness Letter [Newsletter], Vol. 16, No. 2, Nov. 1999. 5 p.

437. VALENTE, T.W. Network models of the diffusion of innovations. Quantitative methods in communication. Cresskill, New Jersey, Hampton Press, 1995. 186 p.

438. VALENTE, T.W., PAREDES, P., and POPPE, P.R. Matching the message to the process: The relative ordering of knowledge, attitudes, and practices in behavior change research. Human Communication Research 24(3): 366-385. Mar. 1998.

439. VALENTE, T.W., POPPE, P.R., ALVA, M.E., BRICEÑO, R.V.D., and CASES, D. Street theatre as a tool to reduce family planning misinformation. International Quarterly of Community Health Education 15(3): 279-289. 1995.

440. VALENTE, T.W. and SABA, W.P. Mass media and interpersonal influence in a reproductive health communication campaign in Bolivia. Communication Research 25(1): 96-124. Feb. 1998.

441. VALENTE, T.W., SABA, W.P., MERRITT, A.P., FRYER, M.L., FORBES, T., PEREZ, A., and RAMIRO BELTRAN, L. Reproductive health is in your hands: Impact of the Bolivia National Reproductive Health Program campaign. Baltimore, Johns Hopkins School of Public Health, Center for Communication Programs, Feb. 1996. (IEC Field Report No. 4) 47 p.

442. VALENTE, T.W., WATKINS, S.C., JATO, M.N., VAN DER STRATEN, A., and TSITSOL, L.M. Social network associations with contraceptive use among Cameroonian women in voluntary associations. Social Science and Medicine 45(5): 677-687. Sep. 1997.

443. VAN HOLLEN, C. Moving targets: Routine IUD insertion in maternity wards in Tamil Nadu, India. Reproductive Health Matters 6(11): 98-106. May. 1998.

444. VAN ROSSEM, R. and MEEKERS, D. An evaluation of the effectiveness of targeted social marketing to promote adolescent and young adult reproductive health in Cameroon. AIDS Education and Prevention 12(5): 383-404. Oct. 2000.

445. VERA, H. The client's view of high-quality care in Santiago, Chile. Studies in Family Planning 24(1): 40-49. Jan./Feb. 1993.

446. VERMA, R.K. and ROY, T.K. Assessing the quality of family planning service providers in four Indian states. In: Koenig, M.A. and Khan, M.E. Improving Quality of Care in India's Family Welfare Programme. New York, Population Council, 1999. p. 169-182.

447. VERNON, R. and FOREIT, J. How to help clients obtain more preventive reproductive health care. International Family Planning Perspectives 25(4): 200-202. Dec. 1999.

448. VICKERS, C.A. Decision making about family planning at family level. In: American Home Economics Association. Home Economics and Family Planning: Resource Papers for Curriculum Development. Washington, D.C., American Home Economics Association, 1974. p. 24-36.

449. VIETNAM NEWS. Vice President lauds family planning workers. Vietnam News (Hanoi, Vietnam), Jul. 12, 2000. p. 1. (Available: <http://vietnamnews.vnagency.com.vn/2000-07/11/Stories/08.htm>)

450. VO VAN KIET. Accelerating the implementation of the strategy on population and family planning to the year 2000. Directive No. 37-TTg. Jan. 17, 1997. 3 p. (Available: <http://www.unescap.org/pop/database/law_viet/vi_015.htm>)

451. VOS, J., GUMODOKA, B., VAN ASTEN, H.A., BEREGE, Z.A., DOLMANS, W.M., and BORGDORFF, M.W. Improved injection practices after the introduction of treatment and sterility guidelines in Tanzania. Tropical Medicine and International Health 3(4): 291-296. Apr. 1998.

452. WALKER, J.R. The effect of public policies on recent Swedish fertility behavior. Journal of Population Economics 8(13). 1995. (Available: <http://www.iza.org/jpe/v08.html>)

453. WALL, E.M. Valued outcomes in the selection of a contraceptive method. Western Journal of Medicine 141(3): 335-338. Sep. 1984.

454. WALL, E.M. Development of a decision aid for women choosing a method of birth control. Journal of Family Practice 21(5): 351-355. Nov. 1985.

455. WALSH, J. Contraceptive choices: Supporting effective use of methods. In: Ravindran, S.T.K., Berer, M., and Cottingham, J., eds. Beyond Acceptability: Users Perspectives on Contraception. London, World Health Organization, Reproductive Health Matters, 1997. p. 89-96.

456. WARWICK, D.P. The ethics of population control. In: Roberts, G. Population Policy: Contemporary Issues. New York, Praeger, 1990. p. 21-37.

457. WEINBERGER, C.W. Population and family planning. Family Planning Perspectives 6(3): 170-172. Summer 1974.

458. WEISBERG, E. The Depo-Provera controversy: Regulatory, medical and social issues. Zambrano, D., ed. Proceedings of the International Symposium on Depo-Provera (medroxyprogesterone acetate) for Contraception. A Current Perspective of Scientific Clinical and Social Issues, Oxford, Nov. 19-20, 1993. Oxford Clinical Communications, p. 27-38.

459. WILLIAMS, T.W., SCHUTT-AINE, J., and CUCA, Y. Measuring family planning service quality through client satisfaction exit interviews. International Family Planning Perspectives 26(2): 63-71. Jun. 2000.

460. WILSON, A. The reproductive health awareness (RHA) model: A qualitative perspective. Advances in Contraception 13(2/3): 339-342. Jun./Sep. 1997.

461. WINIKOFF, B., SEMERARO, P., ZIMMERMAN, M., and STEIN, K. Contraception during breastfeeding: A clinician's source-book. 2nd ed. New York, Population Council, 1997. 39 p.

462. WOLFF, J., AUSTIN, K., and FRICK, G., eds. Miller, J., series ed. Using electronic communications in family planning. Family Planning Manager, Boston, Family Planning Management Development, Management Sciences for Health, Vol. 5 Summer 1996. 39 p. (Available: <http://erc.msh.org/readroom /english/usingec.htm>, Accessed Mar. 21, 2001)

463. WORLD BANK. Improving Women's Health in India. Washington, D.C., International Bank for Reconstruction and Development, 1995. 172 p. (Available: <http://www.worldbank.org/html/extpb/india wom/ indiasum.htm#Health Services>, Accessed Mar. 15, 2001)

464. WORLD FEDERATION OF HEALTH AGENCIES FOR THE ADVANCEMENT OF VOLUNTARY SURGICAL CONTRACEPTION. Ensuring informed choice for voluntary surgical contraception: Guidelines for counseling and for informed consent. 1984. 30 p. (Unpublished)

*465. WORLD HEALTH ORGANIZATION (WHO). Contraceptive method mix: Guidelines for policy and service delivery. Geneva, WHO, 1994. 143 p.

466. WORLD HEALTH ORGANIZATION (WHO). Health benefits of family planning. Geneva, WHO, 1994. 14 p. (Available: <http://www.who.int/rht/documents/FPP-95-11/fpp9511.htm> Accessed Apr. 6, 2001)

467. WORLD HEALTH ORGANIZATION (WHO). Improving access to quality care in family planning: Medical eligibility criteria for initiating and continuing use of contraceptive methods. Geneva, WHO, 2001. 147 p. (Available: <http://www.who.int/reproductive-health/publications/RHR_00_2_medical_eligibility_criteria_second_edition/>)

468. WORLD HEALTH ORGANIZATION (WHO), DIVISION OF FAMILY HEALTH, and UNIT OF FAMILY PLANNING AND POPULATION. Female sterilization: What health workers need to know. Geneva, WHO, Division of Family Health, Unit of Family Planning and Population, 1994. (No. 4) 35 p.

469. WORLD HEALTH ORGANIZATION (WHO) and DIVISION OF REPRODUCTIVE HEALTH. Post-abortion family planning: A practical guide for programme managers. Geneva, WHO, Family and Reproductive Health, Division of Reproductive Health, 1997. 84 p. (Available: <http://www.who.int/rht/documents/RHT97-20/postabortion_family_planning_.htm>)

470. WORLD MEDICAL ASSOCIATION. World Medical Association declaration on the rights of the patient. Adopted by the 34th World Medical Assembly. Lisbon, Portugal, World Medical Association, Sep./Oct. 1981. (Available: <http://www.wma.net/e/policy/17-h_e.html>, Accessed Mar. 7, 2001)

471. YODER, P.S., HORNIK, R., and CHIRWA, B.C. Evaluating the program effects of a radio drama about AIDS in Zambia. Studies in Family Planning 27(4): 188-203. Jul./Aug. 1996.

472. ZAKHAROV, S.V. and IVANOVA, E.I. Fertility decline and recent changes in Russia: On the threshold of the second demographic transition. In: Davanzo, J. and Farnsworth, G. Russia's Demographic Crisis. Santa Monica, California, RAND, 1996. 33 p.

473. ZAMBERLIN, N. New reproductive health law, Buenos Aires, Argentina. Reproductive Health Matters 8(16): 185. Nov. 2000.

*474. ZAVALA, A.S., PEREZ-GONZALES, M., MILLER, P., WELSH, M., WILKSINS, L.R., and POTTS, M. Reproductive risks in a community-based distribution program of oral contraceptives, Matamoros, Mexico. Studies in Family Planning 18(5): 284-290. Sep./Oct. 1987.

475. ZEIDENSTEIN, G. The user perspective: An evolutionary step in contraceptive service programs. Studies in Family Planning 11(1): 24-28. Jan. 1980.

476. ZHU, H.Z. Integration of poverty alleviation with family planning: An interview with SFPC Vice Minister Yang Kuifu. China Population Today, Vol. 13, No. 4, Aug. 1996. p. 2.

477. ZIMMERMAN, M., HAFFEY, J., CRANE, E., SZUMOWSKI, D., ALVAREZ, F., BHIROMRUT, P., BRACHE, V., LUBIS, F., SALAH, M., and SHAABAN, M. Assessing the acceptability of NORPLANT implants in four countries: Findings from focus group research. Studies in Family Planning 21(2): 92-103. Mar./Apr. 1990.

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