Chapter 1

What women want from their contraceptives ... and what we can offer

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The basic ‘universal’ wish underlying any contraceptive activity is to separate sexuality from reproduction and thus provide protection against unwanted pregnancies. The second wish which is also universally found is that the use of contraceptive methods is safe, meaning that the individual health of the woman practising contraception is preserved and not threatened [1, 2]. Apart from the fact that these two wishes have the potential of getting into a conflict-laden relationship (highest efficacy may be in conflict with highest safety) there is a lot of individual ‘prioritizing’ between the two major motives and there are a lot of other wishes of women around contraception as some case vignettes may exemplify:

Dorothy is 17 years old. She has recently fallen in love with Robert, a school mate. In his presence she feels butterflies in her stomach and at a party they had been dancing with very close body contact and they had kissed each other evoking a feeling she had never experienced before. She wants him and she knows that he wants her. Becoming pregnant would be a horror with her being at school and her dreams of becoming a doctor or a teacher would be threatened or destroyed. She wants contraception in which she can completely trust. This is her only and dominant wish.

Her girlfriend Lisa has already had intercourse with John. Lisa is very much concerned about her skin and her attractiveness since John had terminated their relationship quite abruptly. She wants to get rid of all these little pimples and look sexy again. Of course she does not want to get pregnant but more important is looking good and maybe getting John back.

Liz is the same age as Lisa, living in another country. Just recently it has been on the news: a girl of her age who had taken the same pill as her had suffered a blood clot, collapsed and had to be resuscitated, which was successful but had resulted in a severe handicap for the girl. Liz is horrified by the news. She stops taking that pill immediately and she wants contraception that does not have the risk of such a disease or better no risk at all.

Lesley is 33 years old. She has been married to Frank for 10 years and they have two children. They have a good relationship. Sex has become a bit of a routine. She has increased in weight, which is a big concern for her. Her mother has recently been diagnosed with breast cancer. She does not want to become pregnant but more important for her is that she does not increase weight and that she does not develop breast cancer like her mother. She would also like to feel more sexual desire again and be more responsive to her husband's advances like it was before.

Seira is now 35 years old. She has four children and wants to get some rest from procreation. She is a Muslim and leads a life quite strictly according to the rules of Islam. Her biggest concern is that her menstrual cycle would change and she wishes by all means a contraceptive method that has no impact on her natural cycle especially no unexpected bleeding or spotting, which would keep her from praying and keep her from fulfilling her duties towards her husband.
Yvonne is a very successful single business woman. She is also very active in long distance running and has even started with the women’s triathlon. Menstruation is a nuisance to her, which keeps her from activities she likes. She feels bothered by this ‘bloody business’ and has read in a magazine that menstruation is a relic of former times.

Carla is 17 years old. She has to stay at home when these horrible pain attacks at the beginning of her menstrual bleed start. This is not good for her performance at school and she withdraws from all her physical activities and stays in bed with pain killers and a hot water bottle.

As can be seen by these case illustrations there is no simple answer to the question ‘What do women want from contraceptives?’ because women are so different and so different in their wishes, or even in the same woman across her life cycle.

Looking at this question from a population-based view and trying to understand the literature about these issues it appears that women’s wishes can be subdivided into two major groups.

**General wishes of (almost) all women**

**Efficacy**

As mentioned above efficacy seems to be the most important and most general request or wish of women regarding contraceptive methods. They want 100% effectiveness. It seems an inherent wish and a logical request when practising contraception.

This wish can almost be fulfilled because modern contraceptive methods have an efficacy that approaches 100%. To have this high efficacy, modern methods interfere with the normal reproductive physiology (by inhibiting ovulation, destroying sperm capacity to fertilize, interfering with endometrial maturation, etc.) and thus these methods are basically ‘unnatural’. Some women want a high efficacy with little or no interference with nature – a wish which until now has not been fulfilled. It is important to take into consideration these wishes when it comes to counselling and explaining the mechanisms of action.

Regarding efficacy, an unknown number of women may not want an absolutely effective method to keep some risk or chance of becoming pregnant alive [3, 4]. This is a possible conflict between the cognitive wish for contraception and the emotional wish to feel the potency to get pregnant. We do not have empirical studies about the frequency of this internal conflict, but for practical reasons it seems important to keep this possible ambivalence towards efficacy in mind [5, 6].

**Safety**

We can assume and this is confirmed by studies, that all women want to be safe and run no health risks when practising contraception [1, 2, 4, 5]. This is the same across countries and cultures.

There are, however, very large individual differences regarding the acceptability of some risks with respect to the character of the risk and relative height or intensity of the risk.

**Examples**

- There seems to be a higher acceptability of cardiovascular risks compared to breast cancer risk. Women, especially in Western industrialized countries, seem to be more afraid of cancer than of cardiovascular disease, although the mortality of the latter is higher. This has to do with social images of diseases and the emotional attribution to
these conditions, which vary across different ages, educational and socioeconomic levels [7].

- Women (and doctors) seem to have difficulty differentiating between ‘relative risk’ and ‘absolute risk’ and there is in general no understanding of more complex risk parameters like ‘number to treat’ or ‘number to harm’. If a contraceptive method increases the thromboembolic cases among 10,000 users compared to non-users from 3 cases (non-users) to 6 cases (users) per 10,000 women this can be described and communicated as a ‘relative risk’ increase of 2 (doubling the risk) or as a 100% increase.

Depending on how these numbers are communicated the emotional response to this statistical information may be very different. Risks described in absolute numbers usually better reflect real-life conditions [8].

Taking these facts into account, it is understandable that safety perception of a method in a specific country and society is very much influenced by the sources of information and the way risks are described. Contraceptive methods have social images or social stereotypes which may vary over time and may be strongly influenced by single events like a serious complication in a young woman.

The basic problem regarding the wish for safety lies in the fact that there is no effective method without any risk and that methods without any risk lack effectiveness and increase the risk of unwanted pregnancies with its specific risks.

This means for contraceptive counselling that the wish for safety cannot be fulfilled completely and that an important part of contraceptive counselling is what has been called risk counselling. This means informing women in a patient centred way and therefore empowering them to make a decision in their individual interest. It means also that healthcare providers try to understand the individual risk perception and where this perception comes from to increase knowledge and educate women [8].

Side effects and quality of life

Another universal wish is to have no unwanted side effects while using a contraceptive method. These side effects include changes in menstrual pattern, period pain, weight gain, skin and hair changes, mood changes, sexual problems, etc. [9–12].

Here again the tolerability and acceptability of side effects varies to a large extent depending on the individual cultural and educational background. It is noticeable that studies done several years ago have shown that the profile and frequency of side effects when using contraceptives is comparable to those observed among placebo users [9, 10].

Weight gain has a very low acceptability in Western industrialized countries whilst amenorrhea may be well accepted. In other countries weight gain is considered much less of a problem, but amenorrhea may not be acceptable or irregular unexpected bleeding is considered an unacceptable side effect [13].

Changes in sexual function may be viewed as a minor problem in middle-aged women, while this ‘side effect’ may be experienced as very disturbing in adolescents.

Several studies have shown that side effects seem to be the most frequent reason for discontinuing a method and becoming exposed to the risk of an unwanted pregnancy.

Again, it is therefore very important during contraceptive counselling to understand the individual importance given to specific side effects to better adapt the decision to the individual wishes and concerns [14, 15].
Wishes and needs with larger inter-individual and intra-individual variability

Relation to sexual activity
Some women want to practise contraception on demand meaning that contraception is practised in the context of sexual activity only. These women want a method that acts specifically and exclusively on the sexual encounter by inhibiting the ‘individual’ act of fertilization. They do not want methods that need continuous application beyond the sexual act.

This seems to be especially true in countries where modern contraceptives have just recently been introduced.

Other women want to be protected explicitly independent of the sexual act. They find disturbing the direct interaction between a contraceptive method and sexual activity and believe it has a negative impact on the quality of their sexual life. They prefer contraception as a continuous preventive behaviour, which may become a habit and also give more security for unplanned and unexpected sexual encounters [14, 15].

Duration of action
Many women seem to prefer a method that acts for a longer period of time without needing regular daily intervention by the woman. This daily routine can become stressful and lead to failures as studies have shown [16, 17].

Other women, however, feel safer and more autonomous and somehow freer in their decisions if they use a short-acting method.

These wishes seem to be determined by social learning, social class and education.

Control
Women may want control over their contraceptive method (like daily, weekly or monthly self applications). This is often combined with the wish to be independent of others like healthcare professionals, pharmacists, etc.).

Other women want a method that acts without having to think about it. They are not interested in having control but are relieved if the method is applied by a healthcare professional in whom they trust. These women prefer to be put in a state of reversible infertility until the moment when they want to become pregnant [1, 16, 17].

Physical properties, mechanism of action and mode of application
Fertility can be controlled by various properties of methods (hormones, rubber, copper, etc.), by various mechanisms (ovulation inhibition, changes in cervical mucus, endometrial changes, spermicidal action, etc.) and by various routes of administration (oral, transdermal, intravaginal, transnasal, intrauterine, etc.). Fertility can also be controlled by specific sexual behaviour (avoiding sexual intercourse during the fertile days of the cycle).

Women may have very variable wishes regarding the properties, the ways of administration and even the mechanism of action, although the latter seems to be of less practical interest [16, 17].
These variable wishes correspond to intra-familiar learning processes, individual body image, general concepts about nature and are also influenced by the sociocultural environment (religion, media, etc.).

This internal representation of a method is important to understand because this will, among other factors, determine the acceptability and continuation.

**Independence/involvement of partner or other family members**

Wishes regarding the role and/or involvement of the partner vary largely. Many women especially from Western industrialized countries want to be independent of their partner’s decisions or behaviour. Self determination in sexual and reproductive health has become a highly valued issue. Other women still in the same countries would want male partners to be more involved in contraception and to share the responsibility and the load of fertility control. In some countries the involvement of partners or other family members is imposed on the woman due to rules specific to this culture.

In contraceptive counselling we have to try to understand these wishes and sometimes constraints to increase the acceptability of methods.

**Costs**

The wish for a low cost contraceptive method depends very much on the socioeconomic condition of the woman herself and the country in which she lives. This wish may be especially strong and important in young unemployed women. The wish for free contraceptives is fulfilled in some countries and for some special age groups. The focus is generally on adolescent women. On one hand it seems that providing free contraceptives to adolescents increases uptake and continuation, as has been shown in the USA. On the other hand, it remains an interesting fact that in the UK where contraceptives are free, the rate of unwanted pregnancies is still very high.

Elucidation of the wishes and concerns regarding costs is, however, an important part of the dialogue between the healthcare provider and the woman.

**Additional benefits**

Additional benefits of contraception refer mainly to hormonal methods. The benefits include a reduction in heavy menstrual bleeding and dysmenorrhoea, an improvement in premenstrual symptoms, acne and hirsuitism. Women affected by these conditions wish to profit from these non-contraceptive positive effects and may use the method mainly because of these benefits.

Some women may want protective effects with respect to diseases they have experienced in members of their family or in people they know, such as osteoporosis, ovarian cancer and iron deficiency anaemia.

For healthy women not suffering from any of these conditions potentially positive side effects are of no or minor importance.

Condoms have the very important additional benefit of protecting against the majority of sexually transmitted infections (STIs) and as such respond to the wishes of women feeling at risk of STIs. It is interesting to note that the protection against STIs seems to be of less importance for young women compared to the protection against unwanted pregnancies.
Conclusion

The knowledge and understanding of what the individual woman wants is an important part of contraceptive counselling. This part of the contraceptive dialogue is often forgotten in the limited space of time of a contraceptive consultation. Healthcare professionals seem to be very focused on the objective characteristics of the woman seeking advice, rather than what the woman actually wants and is comfortable with. The medical history is certainly important for safety reasons, but it is equally important to take a woman’s personal feelings into account. ‘Subjectivity’ includes wishes, motives, values, priorities, etc., and in this domain the woman is her own expert.

Studies have shown that if healthcare providers do not listen to ‘what women want’, the discontinuation rate of methods is quite high, whilst in those situations in which women’s views and wishes are integrated there is a positive impact on satisfaction and continuation.

One way of assessing the subjectivity of the woman is asking, either during the dialogue in the consultation room or by using a questionnaire in the waiting room, about her expectations and experiences regarding the criteria mentioned above, like efficacy, safety, side effects, relation to sexual activity, duration of action, control, cost, involvement of partner or other family members and additional health benefits.

In our model of structured contraceptive counselling, we recommend that the assessment of the individual needs and wishes of women regarding family planning and contraceptive methods is the first step to a shared decision-making process, in which the healthcare professional acts as an expert in assessing the risk profile of the woman and as a provider of evidence-based information whilst the woman contributes to the process by expressing her wishes and values and by attributing her individual weight to the information given.

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