

Preferences for Contraceptive Attributes: Voices of Women in Ciudad Juárez, Mexico

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Ten focus-group discussions on attributes of contraceptive methods were held in 1994 with 77 low-income women living in 10 neighborhoods in Ciudad Juárez, Mexico. The discussions indicated that the women strongly preferred highly effective contraceptives that would allow users to maintain regular monthly bleeding and that would not cause unpleasant side effects. Monthly bleeding was especially important to these women, since it provided reassurance that pregnancy had been prevented. Secrecy from partners was important to some, but not to the majority of women in the focus groups. Among the numerous obstacles to method acceptance identified were unwanted bleeding problems, partner's objections, fear that an irreversible method might produce intolerable side effects, concern that providers would insert a device without consent, fear of not being able to conceive quickly after stopping use and discomfort with having to interrupt intimacy or touch oneself to insert a method.

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Mexico was one of the first countries to establish a national family planning program when, in 1973, it reversed its pronatalist population policy and set a goal to reduce the annual population growth rate from 3.2% to 2.5% by 1982 and to 1% by 2000; as of 1992,

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however, the population was growing at an annual rate of 2.2%.¹ Since that landmark legislation, Mexico's total fertility rate has decreased by approximately 46%, from 5.7 lifetime births per woman in 1975–1976 to 3.1 estimated in 1992.² As of the end of 1992, the prevalence of modern method use had reached 63% of women in union aged 15–49.³

The consensus attained at the 1994 International Conference on Population and Development in Cairo challenged the population and family planning establishment to adopt a "reproductive health approach" to service delivery that would temper demographic motivations, emphasize responding to the contraceptive and reproductive health needs of individual clients, and work toward the general empowerment of women.⁴ The availability of a full range of safe and effective contraceptive methods that are acceptable to both partners is an integral part of a "client-responsive" family planning and reproductive health program.

While previous research has examined contraceptive acceptability in Mexico, including men's and women's preferences for contraceptive technology,⁵ some studies were restricted to users only.⁶ Few

recent studies have examined what women—especially poor women—like in or want from a contraceptive, or what trade-offs they are prepared to make regarding attributes that they dislike.

This article presents findings from a Mexican case study conducted as part of a larger multicountry investigation of poor women's attitudes toward the attributes of various contraceptives.⁷ We report results from 10 focus-group discussions that were held with women living in the border city of Ciudad Juárez, Mexico.

Methods

The Multicountry Study

As part of the larger multicountry study, focus-group discussions were conducted with a total of 576 women from cities in Cambodia, India, Mexico, Pakistan, Peru, South Africa and the United States. Coinvestigators collectively identified the criteria for focus-group participation before the field research, constructed a uniform moderator's guide and were trained in moderating and observing focus-group discussions. A more detailed description of the multicountry study methodology is available elsewhere.⁸

The questions were styled and ordered to extract information on women's preferences for specific attributes of contraceptives. The guide, divided into five main parts, employed various styles of inquiry: Part 1 assessed the participant's background characteristics; Part 2 polled women on their familiarity and personal experience with different contraceptive methods; Part 3, focusing on these "known" methods, asked women to discuss reasons for use or nonuse; Part 4 asked women to describe the characteristics of their "ideal" method; and Part 5 solicited women's extent of familiarity with and knowledge of various methods that the moderator then displayed or described verbally.

Local Mexican Setting

Most modern contraceptive methods are available in Mexico at no cost through the public sector, the primary source for approximately 62% of current users.⁹ However, injectables, the implant and the female condom are not offered by the public sector; within the private sector, pharmacies are the most popular source of contraceptives and account for 22% of the total (public and private) market share.¹⁰ A wide array of injectable contraceptives has nevertheless been available in pharmacies since the 1970s.^{*11}

The Mexican study site, Ciudad Juárez in the state of Chihuahua, sits along the Mexico-U.S. border, across the Rio Grande from El Paso, Texas. The Ciudad Juárez-El Paso metropolitan area is known for having active *maquiladoras* (multinationally owned factories that employ local labor), heavily traversed international bridges, poor environmental conditions and general poverty.¹²

The Federación Mexicana de Asociaciones Privadas de Salud y Desarrollo Comunitario (FEMAP), a health and community development organization with national headquarters in Ciudad Juárez, collaborated in the study. All participants were clients of FEMAP's community-based reproductive health education and contraceptive distribution program.

The fees charged by nongovernmental providers such as FEMAP are often substantially lower than those asked by local pharmacies or private-sector providers. In addition, FEMAP usually offers methods free of charge to very low income clients. In Ciudad Juárez, FEMAP offers a variety of pills and condoms through its own pharmacies and its community distribution program. Other methods, such as different injectables and spermicidal cream or tablets, are also available at FEMAP pharmacies, while clinicians offer IUD insertion and removal and female and male sterilization at the organization's central medical facility. Currently, FEMAP does not provide the female condom or the hormonal implant.

The Focus Groups

The targeted population for the study in Ciudad Juárez consisted of poor urban women who were aged 15-49 and who had had either a low (1-3) or high (four or more) number of births. Urban rather than rural women were selected to increase the likelihood that participants would have been exposed to modern contraceptive methods.

FEMAP officials identified 10 poor *colonias* (urban neighborhoods) from which to

recruit participants for each focus-group discussion. Female community health promoters affiliated with FEMAP who resided in those neighborhoods identified and recruited participants for the study. The promoters tried to follow strictly the selection criteria for recruitment, but this proved difficult in a few cases where invitations

were made to ineligible women by word of mouth through other people away from the discussions. Thus, although some participants were older than the targeted age, the great majority were still in their childbearing years. In addition, the promoters attended the sessions as observers, and their comments generally helped keep the group dynamics relaxed.

A total of 77 women from 10 neighboring urban colonias participated in the study, and the size of the discussion groups ranged from five to 11 participants. The overall mean age among participants was 30 years (see Table 1). While the level of formal schooling varied widely by study site, only 42% overall had completed primary school (at least six years of education). The large majority of women (83%) were married. Among the 15 unmarried women, eight had a current regular partner. The participants averaged 2.9 living children. Fifty-nine women had no children or three or fewer, 17 had 4-6 and one woman had seven or more.

While the moderator (the first author) conducted each focus-group session, an assistant observed and took notes. Sessions were conducted in Spanish, using a culturally sensitive translation of the common moderators' guide prepared by a lifetime local resident. After an introduction, the moderator distributed a brief questionnaire on personal characteristics and described the study's purpose and methodology. The women were informed that the session would be videotaped and were assured that confidentiality would be maintained.

The moderator and her assistant discussed each session on the same day it was held, while organizing and summarizing relevant notes. After carefully reviewing the videotape, the moderator prepared a verbatim English translation of the sessions on audiotape, which was then transcribed. Ten percent of the transcriptions were randomly selected for independent

Table 1. Selected characteristics of participants in 10 focus groups on contraceptive attributes, by neighborhood from which group was drawn, Ciudad Juárez, Mexico, 1994

Neighborhood	N	Mean age	Age range	Mean no. of living children	% with primary education
All women	77	30	15-52	2.9	42
Melchor Ocampo	5	32	20-43	2.3	83
Insurgentes	10	27	16-45	3.0	27
División del Norte	6	31	21-42	2.3	29
Independencia #1	5	40	27-52	4.3	33
Leyes de Reforma	11	30	15-43	3.2	31
La Cuesta	6	32	24-39	3.4	71
Tierra y Libertad	11	27	20-45	2.5	45
Francisco Madero	8	33	20-48	3.1	30
Mirador	6	28	23-37	3.3	57
Azteca	9	32	21-46	2.1	14

validation of the translation, which was deemed to be of excellent quality.

To permit comparability across the national study sites, the multicountry study coinvestigators originally designated 15 discussion themes; in addition, each investigator identified other country-specific themes. In the Mexican study, 24 themes were identified, and the primary author color-coded and marked the relevant sections of the transcript. She and a coinvestigator independently extracted information related to each theme from the group transcripts and generated aggregate summaries of each theme for all 10 focus groups. There was near-perfect agreement between the summaries of each group's discussion.

Because there was insufficient relevant material for some themes and significant overlap of content for others, the 24 original core themes were consolidated into 13 groupings of related topics.

*For a variety of reasons, including widespread bleeding problems and political concerns, depot medroxyprogesterone acetate (DMPA) was dropped from government clinics during the early 1980s (see C. W. Meade et al., and J. Garza-Flores, P. E. Hall and G. Perez-Palacios, reference 18; and personal communication, Gustavo Martínez, medical director, Hospital de la Familia, Ciudad Juárez, Mexico, March 1997). Nevertheless, at the time our study was conducted, DMPA was readily available in local pharmacies. Monthly injectables (marketed as Perlutal and Pa-tector), however, were the two most commonly available injectables. Half-doses were also available as monthly injectables, but are known to severely disrupt menstrual patterns (and a toxicological review has been recommended for Perlutal). (See: R. Recio et al., "Pharmacodynamic Assessment of Dihydroxyprogesterone Acetophenide Plus Estradiol Enanthate as a Monthly Injectable Contraceptive," *Contraception*, 33:579-589, 1986; reference 11; and M. K. Topozada, "Existing Once-a-Month Combined Injectable Contraceptives," *Contraception*, 49:293-295, 1994.) Although some participants indicated that the bimonthly injectable norethindrone enanthate was also available in local pharmacies, we were unable to find it in three private pharmacies chosen at random. According to a study on the introduction of a new combined monthly injectable, Cyclofem, the Mexican National Family Planning Program will soon be making it available through the public sector (see reference 10). The method, however, was not readily available in pharmacies at the time of our study.

Findings

Knowledge and Use

The methods with which women were most familiar were those with which they had the most direct experience, identified as those “most commonly used in the community.” These included the pill, the IUD and the monthly injectable. However, most women were also familiar with the male condom and sterilization.

Least known were many female barrier methods (the diaphragm, the female condom, the sponge and contraceptive film) and the contraceptive implant. More-

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over, few women knew of rhythm or withdrawal. If women were unfamiliar with a method, that specific method was introduced, displayed and described. (For the implant, drawings were shown.) In one focus group, where the IUD appeared to be especially unknown, the apparatus and insertion rod were also shown.

Most of the women had used the pill at some time or were using it at the time of the study, and many had used or were using the injectable or the IUD. Relatively few had experience with the male condom, spermicides, female sterilization or traditional methods such as rhythm or withdrawal. One woman said her husband was sterilized, and no one acknowledged having used the implant or a female barrier method. (It became clear during the main discussions that women did not always admit to all of their experience of contraception in their initial formal questioning.)

Women’s Preferences for Attributes

•*Method effectiveness.* Effectiveness emerged as a contraceptive’s most important attribute. It was always the first to be mentioned, regardless of whether women were discussing familiar methods, ideal methods or those that had been unknown to them. The pill, one of the most commonly used methods among participants, was felt to be the most effective, and most women preferred it despite the need to take it daily. Some women especially appreciated that they could make up “a couple of missed days” without risking pregnancy.

The perception and assurance of effec-

tiveness provided by “seeing a period” was extremely important, and the popularity of the pill, monthly injections and the IUD reflected this perception. These women considered the missed periods with longer-acting injections (bimonthly or quarterly) quite worrisome, because most could not feel confident of the method’s effectiveness without seeing their periods.

The effectiveness of the IUD was the subject of many conflicting stories. While some women felt quite safe from the threat of pregnancy, others expressed their concern about the IUD moving around in the uterus or falling out entirely. In addition, some women claimed to have friends who had either become pregnant while using one or whose baby had been born with the IUD embedded in its skin.

In discussions of unfamiliar contraceptives, such as female barrier methods, women were primarily concerned with effectiveness. The initial response to barrier methods was predominantly negative, and any residual interest was rapidly lost when women were told that these methods were not completely reliable. As one woman noted, “but that’s the whole point, we need something effective.”

Barrier methods, apart from any other attributes, seemed not worth the trouble because their effectiveness could “not be trusted.” With the male condom, concern about effectiveness focused on the reliability of the man using one, rather than any inherent deficiency in the condoms themselves. There was also a general lack of confidence in rhythm because of its unreliability, except for women whose cycles are very regular or “very punctual,” as one woman put it.

•*Duration of protection and reversibility.* While participants did not identify an “ideal” or preferred duration for a method’s contraceptive effectiveness, other things being equal, long-acting contraceptives were considered better than short-acting ones. The IUD was mentioned only once in this context, and that was to commend its long-term protection compared with that of pills.

Similarly, while women considered the possibility of unpredictable and irregular bleeding to be sufficient reason not to use the implant, women emphasized how attractive they found the prospect of five years of effective protection. As one woman noted, “I think it’s good that it lasts long, but it would be better if it didn’t have

those side effects.” Another commented, “Well sure, if it didn’t have those side effects, I would have two of them [sets] inserted and have it work double-time.”

Interest in a method’s duration of protection was qualified by concern about the ability to reverse its mode of action and side effects when desired. The IUD and the implant were considered more acceptable than the three-month or the proposed six-month injectables, precisely because of their immediate reversibility. Women perceived that long-acting injectables meant stronger doses of the drug, and a greater probability of nonreversible side effects as a result. For the same reason, the monthly injection was preferred to formulations active over longer intervals.

Some women also considered the implant preferable to sterilization because of the implant’s reversibility, should a woman desire children before the full five years of effectiveness. The relative difficulty of removing the capsules, however, made it an “ideal” choice only for “older” women who were more certain than younger women that they had completed childbearing.

•*Return to fertility.* There was significant concern about the return of fertility after contraceptive use. The participants wanted assurance that if they wished to resume childbearing, they would be able to conceive and carry a pregnancy to term. The experiences of four women who failed to conceive after using contraceptives were discussed. (Two had used the pill and another two, an injectable contraceptive.) A fifth woman spoke of rumors about the difficulty of getting pregnant after using an injectable contraceptive. In general, however, the pill and the IUD were commended for their reversibility and the ease with which women could conceive after their use.

•*Secrecy and privacy.* The need for a method that would allow users secrecy arose spontaneously in four of the 10 groups. In most cases, women spoke abstractly about how “some women” would benefit from this attribute if “their partner” did not permit them to practice contraception. Three women explicitly stated that their husbands did not allow them to use any method.

Machismo, it was alleged, led many men to oppose any method of contraception, although women admitted that this is not as common as it was in the past: In six groups, the general consensus was that secrecy was no longer needed, because men “nowadays” were generally supportive of women, some of them even going out of their way to buy pills or injection vials.

In the four groups where women identified secrecy as a concern, they described a pervasive "macho" attitude that led men to stubbornly oppose all contraceptive use, either for themselves or for their female partners. In this situation, women would have no choice but to practice contraception secretly. Generally, however, women thought it would not be difficult to "fool" their partner, since many men did not understand the different methods of contraception.

The issue of privacy arose spontaneously in only one group. When discussing the attributes of the sponge and spermicidal film, one woman humorously referred to the problem of the children finding the sponge and wanting to know about its use.

Side Effects

The timing of menstrual bleeding and its amount were of universal importance to these women. While their experience with the pill was generally positive, many women either had themselves or had friends who had experienced heavy or irregular bleeding with the IUD, and irregular, delayed or missed periods with certain injectables.

Bleeding problems were referred to as "the worst types of problems," and several women had had an IUD removed or had discontinued injectables for that reason. Similarly, while none of the women had tried the contraceptive implant, many were quick to point out that the potential for irregular bleeding with the method provided sufficient reason not to try it (despite their attraction to its long period of effectiveness). As one woman noted, "It seems good to me except for what you mentioned about the changes in your period—the fact that it might come, or it might not come, or it might come more frequently. That's the only thing I don't like about it."

Some women, however, were prepared to trade off a certain amount of heavy or irregular bleeding for the convenience and confidence of a long-term method like the IUD or the contraceptive implant. One woman who had heavier periods with the IUD had it removed only when she began to experience pain.

As noted earlier, the importance of "seeing a period" was mentioned repeatedly as needed for assurance of not being pregnant. Only one person linked monthly periods to the body's need to "clear out regularly;" for everyone else, the issue was the fear of unplanned pregnancy. As one woman described her experience with the injectable,

"I would go crazy wondering if I was pregnant or not!" Another said, "I needed to have a pregnancy test every month!"

Aside from this generally low tolerance for bleeding irregularities, women mentioned other symptoms and side effects that they said were unpleasant and undesirable and, for some, entirely unacceptable. Several women noted that reactions to contraceptives were a very individual matter; typically, women would experiment with different pills or injectable formulations until they found one that suited them. Most injectable or pill users had suffered some side effects, and the problem of abdominal pain with the IUD was mentioned in six of the groups. In fact, women rarely mentioned not experiencing any side effects with a given method. Many would tolerate the side effects of one method for a few months before rotating through other methods and their side effects.

Many pill users of all ages complained of headaches (sometimes severe), general malaise and nausea or vomiting. A couple of women changed to lower dose pills to alleviate symptoms, while others changed their method entirely (most often to the IUD).

Weight gain associated with the pill arose in six of the 10 groups. Several women said that they or their friends felt hungrier and ate more while taking the pill. It was unclear from the discussions whether the weight gain was substantial or small, however, and no one stopped using the pill because of weight gain. In two groups, participants observed that some women gained weight while others lost weight, so weight change was considered an individual matter. Only one woman complained of swelling in her feet.

Two women had experienced feelings of anxiousness, or *nervios*, while on the pill. Anxiety or irritable moods and headaches were similarly associated with the use of injectables. A couple of women complained about "feeling bad," often described as a feeling of persistent "pressure in the head" from the injection. One woman spoke of headaches caused by the injection, which were sometimes so severe that she became anxious, impatient and easily bothered.

Women in three groups also mentioned *nervios* in connection with tubal occlusion, often with the qualification that the propensity for such anxiety was linked to young age at the time of the procedure. Women younger than 25 were often cautioned against undergoing it for this reason. Two women said that their friends or doctor had

warned them not to be sterilized because they might "go a little crazy." A few women who had undergone the procedure, however, shared their experience and assured others that they had not experienced such "craziness" or "hysterics."

Barrier Methods

The most negative comments were generally reserved for the female barrier methods, even though the participants had little experience with or knowledge of them. For example, the women disliked the fact that on the whole, barrier methods were less effective than the more familiar hormonal methods. In addition, participants considered all of the barrier methods that were displayed and discussed to be inconvenient, because of difficulties in insertion and removal, the need to anticipate intercourse or interrupt intimacy, and the nuisance of having to dispose of female condoms and sponges or of cleaning and storing diaphragms. With the diaphragm, there were additional concerns about the need for it to be fitted by a health practitioner, for it to be placed correctly in the vagina and stay in place, and for it to be unnoticed by a partner.

Discussions about the female condom raised the issue of male acceptability more frequently than the discussions of any other female barrier method. Many women felt that most men would object to its use for the same reasons that they refuse to use male condoms. As one participant noted, "If the man doesn't want to use the male condom, he isn't going to want to use the female condom, even if it is something that the woman inserts."

Spermicidal foaming tablets and film seemed to be the least troublesome of the barrier methods. Most women, nevertheless, perceived them as unpleasant, and in three of the focus groups, participants spontaneously expressed their dislike of having to touch themselves to insert the contraceptive. Despite the fact that all of the female barrier methods could be inserted prior to intercourse, most women did not like the fact that they could potentially interrupt intimacy. It appears that in this community, the timing of intercourse is often difficult to anticipate, and a man cannot be relied on to be patient while a woman prepares herself.

Male Methods

The women in most groups had little experience with male condoms, primarily because of the overwhelming consensus that men dislike them and are reluctant to use them. As one woman noted, "that

[condom use] is not really our problem, that's their [the men's] problem if they want to use it, if they want to protect us from getting pregnant. It's completely their decision." According to participants, men complained about the loss of sensation, saying "it's like sucking on a candy with the wrapper still on!" or that "there's no need to use a mask." While the women believed that their partners understood that condoms protected against sexually transmitted diseases (STDs), they were quick to point out that understanding this advantage did not necessarily increase a man's desire to use them. However, several women and a couple of the promoters speculated that while men would not use condoms with their wife, they probably used them with other women.

Most of the women appreciated the fact that condoms have none of the side effects of hormonal contraceptives and that they offer protection from STDs. However, women who had used the method were generally vocal about how unnatural or "strange" condoms felt and smelled, and only a couple claimed that the physical sensation was the same with or without a condom. Some women were also concerned about interrupting intercourse and the possibility that their partner would lose his erection.

The few women who reported that their husband used condoms regularly said they were very happy that he assumed responsibility for contraception. However, one older woman, whose husband had used condoms for several years when they were the only option, described her anxiety about having to rely completely on him, and how she had become pregnant too soon.

Half of the groups discussed other male methods. Although vasectomy was identified as an ideal method in two groups, one group noted men's strong resistance to vasectomy, and another agreed on the need for more education to reassure men that the operation does not threaten their virility. Four groups wanted more methods for men, and several women asked, "Why aren't scientists developing anything for men?" Women agreed that a new male method would need to be easy to use, because "they [men] are so hard to convince." Participants believed that a one-time pill or injection that offered long-term protection would be most appealing to men.

Service Delivery Problems

Overwhelmingly, the most common service-delivery complaint concerned IUD insertion and removal. In nine of the 10

focus groups, women discussed rumors or personal experiences of an IUD being inserted postpartum without consent, or of service providers not wanting to perform a requested removal. Among the 24 women who had ever used the IUD, five said their IUD was inserted without consent, and two women had to argue with service providers to get theirs removed. The Mexican Social Security Institute was most often mentioned in this regard.

Women rarely complained about other providers, however. Contraceptives were available from several sources and women had no difficulty obtaining them. The majority felt comfortable obtaining their methods from the promoters, whom they trusted; in fact, many women who purchased vials of injectable contraceptives asked a promoter to administer the injection for them. Women mentioned being able to easily obtain supplies from local pharmacies, where medical prescriptions are not required. There was very little discussion of cost, and only one woman said that she could not afford her monthly injection.

Misinformation

Throughout the discussions, there was evidence of factual misinformation and of general misconceptions regarding contraceptives and their appropriate use. Some women mentioned that when they first started taking the pill, they were unsure of how to take it. Many women also seemed unaware of common bleeding problems associated with pill use, such as lighter monthly periods and occasional breakthrough bleeding. For example, one woman became pregnant after she stopped taking the pill midway through her pill pack because she had begun spotting in midcycle and believed her period had arrived early. Her action suggests that women extrapolate from the experience of taking a daily pill and perceive it as a method that provides daily rather than monthly contraceptive protection. As another example of this misperception, one promoter said she advised women to take their pill in the evening, before their husband arrived home from work, in case the couple engaged in intercourse that evening.

Women displayed little technical knowledge about several methods. For example, the majority of women had never seen an IUD, were unaware of its mechanism of action and did not understand how it was secured. Similarly, even though some women had undergone sterilization, other women were confused about the physiological difference between a tubal operation and a hysterectomy.

Regarding the implant, some women did not understand how rods inserted in the arm could affect the reproductive organs. This issue of a method's proximity to the reproductive system did not arise with injectables, however, as most women did not question the injectables' mode of action and were aware of the method's availability in one-, two- and three-month formulations.

Abortion

Perceptions of abortion as a "method" were probed in the initial part of the focus-group discussions, when the moderators attempted to distinguish between known and unknown methods. When asked, "What about abortion as a method? Is it practiced in this community?" women most frequently responded with blank stares and quiet shaking of their heads in the negative. After a moment of awkward silence, someone would inevitably speak up, commenting that, "Here you don't see that very much, but in some of the other communities further away, maybe you do ... (pause) ... No, you don't see it."

Some of the other typical responses included "It's not as big a problem as it was years back, precisely because of the greater availability of family planning services," and "Yes, sometimes it happens, but most often with single mothers. Often they get desperate and they resort to abortion." (In Mexico, abortion is illegal except in instances of rape, incest or threat to the woman's life.¹³)

Sexuality

Sexual relations and sexuality were not a primary focus of this investigation, but they nevertheless arose indirectly in a variety of contexts, most frequently in discussions of the male condom and barrier methods.

Women openly discussed or alluded to their partners or to "men" in general when discussing their own preferences for contraceptive attributes. While most women felt that they were the decision-makers regarding contraception, men's opinions and feelings were not to be taken lightly. Some women, for example, pointed out that men sometimes expressed concerns about condoms other than the loss of sensation: "They [men] say that they don't feel like men when they're using it." While women often regarded such comments humorously, they nevertheless valued their partner's opinions. They also talked about how their partner might not be so understanding about the need to interrupt intimacy to insert the female condom or

another barrier method. One woman logically asked, "What are you supposed to tell your husband? 'Get off and wait over there for a few minutes until I'm ready.'"

The topic of sexuality also arose in allusions to men's potential for promiscuous behavior. Many men were labeled *vagos* (tramps) who were "always in the street." As one woman put it, "Men, you know, they may have their own shade and swimming pool, but then they want to go and take a dip in someone else's pool, and I don't want him bringing infections from someone else's pool to mine." Comments of this sort were often met with laughter and casual agreement. No woman specifically mentioned that her husband or partner was a vago, but such tales of promiscuity recurred in discussions of sexual relationships.

Sexuality also arose in discussions about the risks of contracting STDs. The women acknowledged that most men were aware that certain infections and diseases could be contracted sexually. The women were also aware that if they suspected their partners of infidelity, then they too were potentially at risk of an STD.

However, this awareness did not guarantee that men would protect themselves by using condoms in "other relationships," or that the women themselves would insist on condom use. In one group a woman said, "They know but that doesn't matter, they still won't use condoms." Another added, "Also, we don't make them use [condoms]. We don't force them to. Maybe if we were a little more forceful they would have no choice, they would just use [condoms]." Finally, a third woman commented, "I think that if we tried to make them use [condoms], then they would just not want to have sex with us anymore. And that would be the end of it."

Discussion

According to the focus-group discussions, method effectiveness, regular monthly bleeding (partly as an indicator of effectiveness) and a lack of side effects were the three most important considerations determining the popularity of methods, with effectiveness being the most desired attribute.

These findings are generally consistent with those from two earlier studies conducted in Mexico.¹⁴ One study, conducted among semirural Indians in the late 1970s, identified method effectiveness and the expectation of side effects as the most significant attributes influencing acceptability.¹⁵ Another study, conducted in the late 1970s by Folch-Lyon and colleagues, relied on focus-group discussions in dif-

ferent parts of Mexico, as well as a nationally representative survey of both urban and semiurban men and women. In that study, the majority of respondents ranked not endangering health and method effectiveness as the two most important attributes in a method, with effectiveness being second in importance.¹⁶ In fact, at the time the latter survey was conducted, the methods believed to pose the greater danger to women's health were the most popular methods in our study—the pill, injectables and the IUD.

These contrasting findings raise two points. First, in the Folch-Lyon questionnaire, respondents were asked to rank lack of danger to health and effectiveness in importance; in our focus groups, we did not ask women to rank attributes in this way. Second, women identified very different types of health threats in the two studies. In the study conducted in the late 1970s, for example, participants cited nervousness, malformed babies and cancer as potential side effects of methods; in our study, on the other hand, most complaints concerned the less serious systemic side effects associated with hormonal methods. (Only three women mentioned cancer and sterility as potentially serious consequences of long-term hormonal use.) The difference in women's level of concern may reflect changes over time in the perception of the relative safety of these methods.

In our study, "bleeding problems and irregularities" were among the least tolerable side effects, and amenorrhea was the least acceptable of all. This aversion to bleeding disturbances is consistent with findings from numerous other studies conducted in Mexico and elsewhere.¹⁷ Further, in several Mexican clinical trials of long-term injectables (such as DMPA and norethindrone enanthate), amenorrhea emerged as a significant reason for method discontinuation.¹⁸ Amenorrhea was also the primary reason for method discontinuation in a study conducted among rural women in six Mexican states in the mid-1980s.¹⁹

According to our study, amenorrhea associated with long-acting injectables such as DMPA is a serious obstacle, even when it is an expected and understood side effect. While other studies indicate that women's interest in regular periods largely reflects cultural beliefs that the body needs to "cleanse" itself or expel "weak

blood,"²⁰ women in Ciudad Juárez emphasized that regular menses reassured them that they were not pregnant. In fact, the primary reason why women preferred monthly injections to longer-acting formulations was the presence of regular monthly periods.

While participants claimed to believe that the longer-acting injections were effective, in practice the experience of amenorrhea often caused women to doubt it. Given the

"As the discussions about barrier methods showed, while men may now agree to family planning in principle, they may not yet be willing to inconvenience themselves in practice."

option, many women switched to methods that allow a monthly menses. Similarly, while many women displayed an interest in the long-term effectiveness of the contraceptive implant, nearly all of them were discouraged by the method's unpredictable and irregular bleeding patterns.

Comparing our findings with research conducted in the late 1970s in Mexico indicates that men's attitudes toward broader family planning concerns are changing.²¹ Most women in our study noted that men's attitudes regarding both family size and personal responsibility in contraceptive decision-making appear to be evolving. The majority of participants felt that most men "nowadays" were more accepting of the need for family planning than men had been in the past. In fact, several women in supportive relationships mentioned that fertility decisions were mutually discussed and agreed upon; these women's partners often displayed their support by purchasing contraceptives for them.

At the same time, women in Ciudad Juárez clearly recognized that they still bore the primary responsibility for fertility regulation. Despite the progress in men's attitudes, women were cautious about the use of methods that could potentially interrupt sex. Indeed, men's responses to the use of specific methods wove in and out of most discussions. As the discussions about barrier methods showed, while men may now agree to family planning in principle, they may not yet be willing to inconvenience themselves in practice.

Our use of focus-group methodology allowed us to engage Mexican women in

a structured yet free-flowing exchange about their preferences for specific contraceptive attributes. Indeed, these discussions reveal a rich narrative of information that, in turn, provides insight into how women perceive a variety of method attributes and how they respond to related issues.

While several of these observations are consistent with findings from past studies, the significant differences that emerged highlight the fact that the formation of personal attitudes, opinions and preferences reflects dynamic rather than static processes. Three major domains appear to be shaping these women's attitudes and preferences—domestic status and conjugal relations, interactions with service providers and personal health concerns. Our study underscores the value of future monitoring of women's and men's evolving interests and needs for contraceptive technologies.

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Resumen

En 1994, se llevaron a cabo 10 grupos focales para analizar los atributos de los métodos anticonceptivos entre 77 mujeres de bajos ingresos, residentes en 10 barrios de la Ciudad Juárez, México. Las deliberaciones dieron por resultado que las mujeres tienen una gran preferencia por los anticonceptivos altamente eficaces que le permitan a la usuaria mantener su sangrado mensual regular y que no le cause efectos secundarios desagradables. El sangrado mensual era especialmente importante para estas mujeres, porque les permitía confirmar que se había prevenido un embarazo. La posibilidad de practicar la anticoncepción sin que su pareja se enterara también fue un importante aspecto para algunas, pero no para la mayoría de las participantes. Entre los numerosos obstáculos para la aceptación de los métodos se mencionaron los problemas del sangrado no deseado, las objeciones de la pareja, el temor que un método irreversible podría producir efectos secundarios intolerables, la preocupación de que los suministradores del servicio les insertarían un dispositivo sin su consentimiento, el temor de no poder concebir rápidamente después de suspender el uso de anticonceptivos, y la molestia de interrumpir un momento íntimo o tocarse para insertarse un método anticonceptivo.

Résumé

Dix discussions de groupe consacrées aux attributs des méthodes contraceptives ont été organisées en 1994 avec 77 femmes à revenus modérés issues de 10 quartiers de la municipalité de Ciudad Juárez, au Mexique. Ces discussions indiquent une nette préférence pour les contraceptifs hautement efficaces caractérisés par le maintien de règles régulières et l'absence d'effets secondaires désagréables. La menstruation s'est révélée particulièrement importante pour les participantes, qui y voyaient l'assurance d'une grossesse évitée. La pratique secrète de la contraception, à l'insu du partenaire, était importante pour certaines participantes, mais pas pour la majorité. Les obstacles suivants ont été relevés parmi les nombreuses objections aux méthodes: problèmes de saignements indésirables, objections du partenaire, crainte d'effets secondaires intolérables susceptibles d'accompagner une méthode irréversible, crainte d'insertion d'un dispositif non désiré par un prestataire de services, crainte de ne pas pouvoir concevoir un enfant rapidement après l'arrêt de la méthode et gêne liée à la nécessité d'interrompre des rapports intimes ou de se toucher pour insérer une méthode.