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## HOUSEHOLD DECISIONMAKING AND CONTRACEPTIVE USE IN ZAMBIA

Unmet need is the percentage of women who do not want to become pregnant but are not using contraception.

41%

The percentage of births in the previous five years that were unwanted at the time of conception.

Women in this study who gained access to free contraception with their husbands were 25% less likely to use a concealable form of contraception than women given access alone.

Family planning services promote a wide range of health and socioeconomic benefits to women, men, and their families. Still, many barriers prevent women from using contraception (see box, page 3). Despite efforts to increase awareness and improve access to these family planning services, unmet need for family planning and unwanted pregnancies remains high in many low- and middle-income countries, suggesting that other factors may be driving contraceptive use. One such factor relates to household decisionmaking about fertility. Specifically, disagreements between a husband and wife about family planning may influence decisions about contraceptive use. Common sources of disagreements between partners include:

- Preferences for whether or not to use family planning.
- What contraceptive method to use.
- Mismatches in ideal family size.

Where spouses voice different preferences and attitudes toward family planning, there is speculation that many women might not use modern contraceptives because their partners disapprove of such methods. Or, alternatively, that they might obtain family planning services secretly and use concealable methods of contraception. Secret use of contraceptives has drawbacks for a marriage that may or may not outweigh the family planning benefits for women. Secret use of contraceptives may introduce mistrust in the marriage, though it could also improve the welfare of women and their children by, for example, increasing the amount of time between each birth. Using contraception in secret, or completely forgoing its use, may detract from agreements that couples have about spacing and limits on family size, with the result that the couple either has more children or has them more frequently than either one wants.

This brief presents findings and policy implications from a study by Nava Ashraf, Erica Field,

and Jean Lee. They investigated the husband's role in family planning decisions and presented evidence that couples' behavior regarding decisions about contraceptive use produce less than ideal fertility outcomes.<sup>1</sup> The study randomly assigned individuals to three groups: individuals chosen to receive a voucher, granting immediate and free access to a range of contraceptive methods, including concealable contraceptives such as implants or injectables, in the presence of their husband (couples treatment); women chosen to receive the same voucher, except in private (individual treatment); and women who did not receive a voucher (control group). The figure on page 2 illustrates the different stages of the study.

### Despite Available Family Planning Services, Unmet Need Is High

Ashraf, Field, and Lee conducted the study in Lusaka, Zambia, a city where unmet need remains high even though family planning services are readily available through public and private sources. According to the 2001-2002 Zambia Demographic and Health Survey, one of every four women ages 15 to 49 reported having an unmet need for family planning, and one of every two women revealed that her last pregnancy was unwanted at the time of conception.<sup>2</sup> Contraceptive use in Zambia is low: Only 33 percent of married women reported using a modern method of contraception in 2007.<sup>3</sup>

Pharmacies and health posts primarily distribute condoms and contraceptive pills, while clinics offer a wider selection of modern methods (injectables, implants, and intrauterine devices). In principle, all modern methods are freely available through public clinics; however, service providers

experience frequent stockouts and patients often have to wait a long time for an appointment.

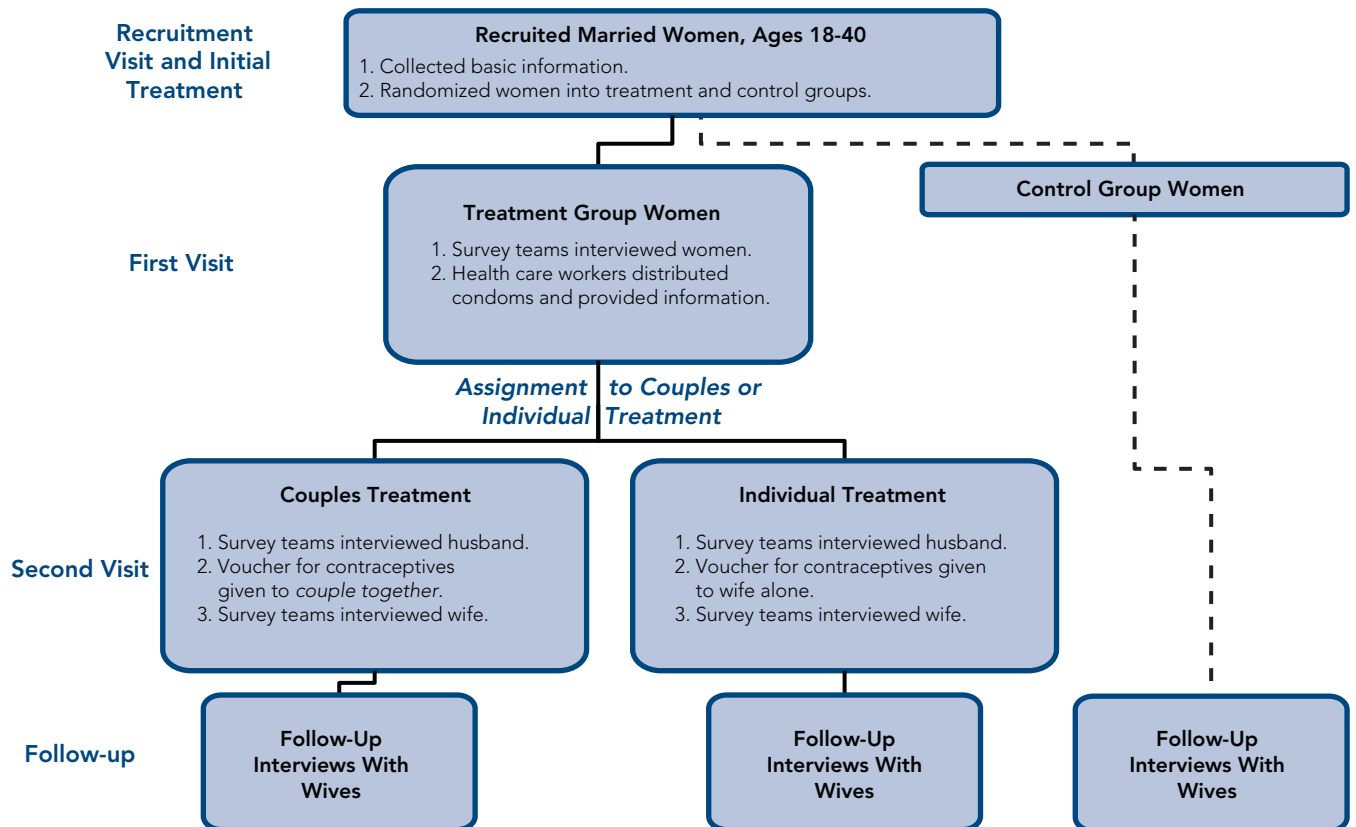
Until 2005, Zambian law required women to obtain explicit permission from their husbands in order to acquire publicly distributed contraceptives. Anecdotal evidence indicates, however, that many health care providers, particularly in rural regions of Zambia, still refuse to distribute contraceptives to women without their husbands' consent. Earlier studies as well as qualitative reports from this study also indicate that men are generally suspicious of their wives using contraception without their knowing, which has contributed to increasing marital tension in households. One woman from the study noted, "women are ever worried, especially those on pills because it's not easy to hide pills in these small houses of ours. For the injectables, they are less worried because a man cannot easily tell unless he pushes/pressures you as to why you are not conceiving."

## Study Background

Women were recruited to the study from the area served by the Chipata Clinic, a large government clinic that provides services to low- and middle-income neighborhoods in Lusaka. Married women ages 18 to 40 were invited to participate in the study if they satisfied the following six criteria:

- They currently lived with their husband.
- They had last given birth between January 2004 and December 2006.
- They were not currently pregnant.
- They had neither been sterilized nor had a hysterectomy.
- They were not known to have health conditions that would preclude the use of hormonal contraceptives.
- They agreed to participate in an initial recruitment survey and information session about family planning together with their husband.

## Stages of the Study



Source: Adapted from Nava Ashraf, Erica Field, and Jean Lee, "Household Bargaining and Excess Fertility: An Experimental Study in Zambia," 2nd revision requested, *American Economic Review* (December 2012).

During the initial stage of the study, researchers determined that a total of 1,799 women met the six criteria, and then randomly assigned 1,031 women to the treatment group and 768 women to the control group. Participants assigned to the treatment group (either in the presence of their husband or in private) received a voucher for free and immediate access to a wide range of contraceptives at the Chipata Clinic. The voucher guaranteed a maximum wait time of one hour and guaranteed access to injectables and contraceptive implants, two methods known to be frequently out of stock.

Women in the treatment and control groups provided health, social, and family information, including marriage and childbearing history, school enrollment of children, fertility preferences, decisionmaking in the household, and current contraceptive use.

Information collected during this first visit indicated that a high proportion of women hide contraceptive use from their husbands. Among the one in four men in the sample who claimed that they were “not doing anything to prevent pregnancy,” almost 60 percent had wives who separately reported that they were using some method of family planning. After the interviews, community health workers delivered information about family planning and the prevention of sexually transmitted diseases (STDs). At the end of the first visit, participants received a three-pack of condoms. Husbands were not present when the women answered questions, nor when they received the health information.

To answer the question about the husband’s role in the family planning decisionmaking process, researchers varied the manner in which they distributed vouchers to participants in the treatment group. Prior to the second visit, about one-half of the women in the treatment group were randomly assigned to receive the voucher in the presence of their husband (couples treatment), while the rest were given the voucher in private (individual treatment). In the couples treatment, the husband was first surveyed alone, and then husband and wife were brought back together to receive the voucher. (The couples treatment emulates the family planning decisionmaking process in many low- and middle-income countries, allowing the husband to veto decisions regarding contraceptive choice.) In contrast, women assigned to the individual treatment received the voucher during a private session with the community health worker.

Data from clinic records and logs kept by the registered nurse on participants’ family planning visits and contraceptive use were used for short-run analysis. A follow-up visit and survey of women administered two years after the intervention were used for long-run analysis.

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## Barriers to Contraceptive Use

Zambian women face many barriers to family planning and contraceptive use, most of which relate to their ability to access them or their knowledge of the contraceptives.

### Access

- Lack of access due to physical/geographical barriers between households and service providers (e.g., large distances between households and clinics, poor access to transportation).
- Poor access to contraceptives due to frequent shortages (stockouts) in clinics and health centers.
- Long waiting times for service appointments or counseling.
- High costs of contraceptives.
- Limited choice of contraceptive methods.

### Information/Awareness

- Fear of side effects.
- Misinformation or lack of information about family planning and contraception.

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## Involving Husbands Decreases Voucher Redemption and Contraceptive Use

Almost half of all women (48 percent) who received a voucher for family planning services traded in the voucher to receive free contraceptives. Fifty-three percent of women in the individual treatment group redeemed the voucher, compared with only 43 percent of women in the couples treatment group, implying that giving husbands the opportunity to participate in family planning decisions decreased voucher redemption rates.

The researchers predicted that couples who do not agree on the number of children they want will respond differently depending on whether vouchers were given to the wife individually or to the couple together. Assignment to the individual treatment provided wives with an opportunity to hide contraceptives. The researchers found that women in the study who desired fewer children than their husbands desired were 25 percent less likely to redeem a voucher for contraception when they received the voucher with their husbands.

Researchers conducted in-depth interviews in conjunction with follow-up surveys to verify that the difference in redemption rate was the result of a woman’s desire for a concealable form of contraception. Their analysis suggests that greater use of the vouchers by the individual treatment group may

be largely attributable to women trying to circumvent their husband's control of family planning decisions.

The research also showed a difference in redemption rates for injectable contraceptives, considered to be more concealable than other forms of contraception. Women in the couples treatment group were 25 percent less likely to opt for injectable contraceptives than women in the individual treatment. Among the subgroup of couples in which men desired more children than their wives, the difference between the two treatment groups was even greater: Women were 48 percent less likely to choose injectable contraceptives when their husbands were present.

## Husband's Involvement Influences Use of Contraception, Even When Couples Agree on Short-Term Fertility

The study results have shown that when couples do not agree on their desired number of children, women who gain access to family planning by themselves are more likely to access it and to use concealable forms of contraception. In contrast, the researchers looked at those households in which neither the husband nor the wife wanted children during the next two years to determine whether a disagreement about their long-term fertility desires affects a husband's preference for contraception. One would expect these couples, who agree about the number of children they want in the short term, to choose the most effective and cheapest form of family planning.

The analysis reveals that use of family planning services and preference for injectables is significantly higher when women in this group access family planning services without their husbands present. When couples agree on their desired number of children, however, the treatment assignment has no effect on their redemption of the voucher, nor on their preference for injectable contraceptives. These results imply that men are reluctant to have their wives use injectable contraceptives, a cheaper and more effective form of birth control, in order to maintain control over household reproductive health outcomes. The analyses and their implications point to strong evidence that there are household dynamics that may lead couples to less-than-ideal fertility outcomes.

## Hiding Contraceptive Decisions Can Complicate Household Dynamics

In general, simply increasing access to contraception does not necessarily lead to an increase in its use. In this study, however, women who gained access to contraception alone were more likely to use it. In addition to increased voucher redemption and use of concealable contraceptives, the researchers found that use of family planning services during the study was associated with a 27 percent reduction in

births, concentrated among those women who wanted to limit childbearing and believed that their husbands desired more children than they did.

While the results highlight that women receiving family planning services alone are better able to use a concealable form of contraception and meet their own fertility goals, the researchers also found evidence that suggested mistrust and suspicion among these couples. A husband may become suspicious of his wife if she goes for a long time without getting pregnant, which could lead to friction or conflict within a marriage. In this study, among those couples in which the husband wanted to have more children than his wife, those in the couples treatment group reported being happier and healthier than women in the individual treatment group.

A trade-off thus exists when providing a woman the opportunity to opt into family planning in private rather than with her husband present. There is the potential for increased use of contraceptives, which could improve health outcomes, but accessing family planning in private could also lead to more unhappiness between husband and wife.

## Policy Implications

Household decisions about contraceptive use have implications for achieving the desired number of births and for marital relationships. Increasing access to contraception will not necessarily lead to increased use of contraception or lower fertility. Providing concealable contraceptives to a married woman without her husband knowing may improve access; however, it may have detrimental consequences for her marriage, regardless of whether it reduces unwanted pregnancies in the short term.

While male involvement in family planning decisionmaking is important for the welfare of the couple, simply making men aware of family planning opportunities or increasing their role in the decisionmaking process may actually decrease contraceptive use among their wives. Successful interventions must help men better understand the costs of childbearing and child care—the costs to women and the costs to their families. Policies that aim to improve access to family planning and to educate men may be most effective in increasing contraceptive prevalence, reducing unwanted pregnancies, and alleviating unmet need for family planning.

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