of unmet need for birth spacing and failure to avoid mistimed pregnancies remain unacceptably high," the investigators conclude.—S. London

**REFERENCE**


---

**In Tanzania, Women Can Correctly Assess Whether They Can Use the Pill**

Tanzanian women of reproductive age can accurately determine whether they are ineligible to use combination oral contraceptives because of medical reasons such as blood clots or diabetes, according to a cross-sectional study conducted in rural and peri-urban regions.1 Overall, the women’s own assessment of their eligibility or ineligibility, as aided by a poster depicting medically valid contraindications, agreed with the assessment of trained nurses in four out of five cases. Only about one in nine women who said they were eligible were found to be ineligible by nurses.

The study was conducted in 2010 in Tanzanian drug shops that were accredited to dispense combination oral contraceptives to women after assessing their eligibility. The investigators trained nurses to use the 2008 update of the World Health Organization’s Medical Eligibility Criteria for Contraceptive Use to screen women for medical contraindications. The nurses approached women who were visiting drug shops (regardless of the reason for their visit) in Tanzania’s Ruvuma and Morogoro regions and asked them to assess their eligibility to use oral contraceptives with the help of a poster. The poster had text and images depicting the World Health Organization contraindications; pregnancy was also included as a contraindication, given that it obviates the need for contraception. The nurses then assessed the women’s eligibility using a checklist of the same contraindications, and measured their blood pressure. Both women and nurses provided the reasons for their eligibility decisions. The investigators calculated the accuracy of the self-assessments, using the nurses’ assessments as the gold standard.

Of the 2,395 women approached by the nurses, 1,776 met the study’s eligibility criteria (they were aged 18–39 and literate) and 1,651 agreed to participate. On average, participating women were 28 years old and had two children. Most were married or cohabiting (71%) and had no more than a primary school education (72%). Fifty-eight percent had used oral contraceptives at some time.

From the self-assessments, 29% of the women concluded that they were ineligible to use oral contraceptives, a proportion similar to the 27% who were ineligible according to the nurse assessments. The overall agreement between self-assessments and nurse assessments was 81%. Only 8% of women said that they were eligible when in fact they were not, and 11% said that they were not eligible when in fact they were.

Women who were ineligible to use oral contraceptives correctly classified themselves 70% of the time (corresponding to the sensitivity of self-assessment), and women who were eligible to use the method correctly classified themselves 85% of the time (corresponding to the specificity of self-assessment); those who said they were eligible were more likely to be correct than those who said they were ineligible. In bivariate analyses, women had an elevated likelihood of correctly assessing their eligibility if they had at least a secondary education (odds ratio, 1.5), had previously used oral contraceptives (1.4) or were currently using any method (1.4).

The most common medically valid reasons given for women’s ineligibility to use oral contraceptives were current or possible pregnancy, current breast-feeding of an infant younger than six months, severe headaches and hypertension. Each was cited as the reason for ineligibility in 1–5% of self-assessments and 3–7% of nurse assessments.

However, 14% of women and 3% of nurses gave medically invalid reasons for ineligibility, such as fear of side effects and partner disapproval of family planning. In an analysis restricted to women who reported only medically valid reasons for illegibility, self-assessment had a sensitivity of 63% and a specificity of 97%. Moreover, some participants—notably those who were pregnant or breast-feeding—would not have been screening themselves for oral contraceptive use under real-world circumstances; when these women were excluded from the analysis, along with those classified as ineligible for medically invalid reasons, the proportion of women who were ineligible to use the pill was 13% according to self-assessment and 9% according to nurse assessment.

Nurses deemed only 3% of women to be ineligible for oral contraceptive use because of hypertension, despite the fact that 11% of women had blood pressure at or above the threshold for ineligibility proposed by the World Health Organization (140/90 mm Hg). However, the authors note that the health risks posed by pregnancy may exceed the risk of oral contraceptive use among women with hypertension.

Taken together, the study’s findings show that “poster-based self-screening is a good test,” according to the investigators. They propose that women’s ability to accurately self-assess their contraindications to combination oral contraceptives may also apply to progestin-only contraceptives, such as injectables, which have fewer contraindications and potentially could be administered by trained staff in drug shops. “The present results support the case for over-the-counter sales of [combination oral contraceptives] with self-screening for contraindications by women in Tanzania,” they conclude.—S. London

**REFERENCE**


---

**Women’s Autonomy Not Always Related to Men’s Help with Maternal Care**

Increases in women’s autonomy and in men’s involvement in maternal health care—two social trends that may contribute to improved maternal health outcomes—do not necessarily occur in tandem, according to a recent study conducted in rural Nepal.1 Instead, the researchers find that aspects of women’s autonomy bear both positive and negative relationships to a husband’s involvement in pregnancy care. For example, women’s autonomy in making economic and domestic decisions is negatively associated with the likelihood that they had discussed their health with their husband during pregnancy and that the husband had attended antenatal care visits (odds ratios, 0.5–0.85). However, women who report higher levels of spousal communication on community, health and reproductive issues—another measure of autonomy—have elevated odds of having discussed their health with
The data come from a mixed-methods study fielded in four rural villages in Kailali district in 2011. The researchers interviewed 275 married women, randomly selected from local health records, who had had a live birth in the previous year and had lived with their spouse at the time of pregnancy, delivery and the survey. To assess husbands' involvement in four aspects of maternal health, the researchers asked women whether their spouse had discussed her health during her most recent pregnancy, made preparatory arrangements for the birth, accompanied her to antenatal care visits and attended the delivery. They also evaluated four types of women's autonomy: economic and domestic autonomy, which measured in terms of whether certain household decisions were made by the women (either alone or jointly with their husbands); movement autonomy, defined by whether women needed permission to go to the market, the local health facility, group meetings, friends' or relatives' houses, and religious institutions; and spousal communication, defined as speaking with one's husband about community affairs, money, desired family size, health and use of family planning. Positive responses to the autonomy questions were summed to create five-point scales in addition, women were asked to provide social and demographic information, including ethnicity, marriage type (love or arranged), and education levels for themselves and their husband.

The researchers also conducted 16 in-depth interviews with married women and men, mothers-in-law and members of the health service community, as well as two focus group discussions (one with women and one with men).

Themes emerging from the qualitative data included perceptions that social norms were gradually changing to accept greater male involvement in maternal health care, although participants indicated that some men who offer assistance to their pregnant wives experience stigma. Husbands were perceived to provide social support and advice to their pregnant wives, but were generally said to be absent during antenatal visits; husbands participating in the study, however, expressed interest in increasing their involvement in their wives' care.

On average, women who took part in the quantitative survey were 23 years old, had married at age 18 and had had their first child just over a year later. Some 53% reported being in a love marriage, rather than an arranged one, and 75% lived in a household that included family members other than their spouse and children. During their most recent pregnancy and delivery, 97% of women had had at least one antenatal care visit, 72% had delivered with the assistance of a skilled provider and 69% had given birth in a health facility.

More than four-fifths of women reported that their husband had discussed their health with them during the pregnancy and prepared for the birth (e.g., by saving money or arranging for transportation). Some 78% indicated their husband had been present at delivery, though this proportion was lower among those delivering in a health facility (59%), and a substantial minority of women (41%) said their husband had attended antenatal care appointments. On the five-point autonomy scales, women scored lowest on economic (1.7) and movement (2.3) autonomy; mean scores were higher for domestic decision making (4.0) and spousal communication (4.5).

A bivariate analysis showed that women's autonomy and other characteristics were associated with husbands' involvement in maternal health care. Women's economic autonomy and domestic autonomy were both negatively associated with couples having discussed the woman's health during pregnancy (odds ratios, 0.8 and 0.7, respectively), and women's domestic decision-making autonomy and movement autonomy were negatively associated with husbands' presence during antenatal care (0.8 and 0.7). Women's domestic and movement autonomy and spousal communication were positively associated with husbands' birth preparedness (1.1-1.8); spousal communication was also positively associated with both discussion of the wife's health during pregnancy (1.8) and the husband's presence at delivery (1.6). Arranged marriage was a strong predictor of having discussed maternal health (3.4), and husbands were generally more likely to have been involved in pregnancy care if they or their wives had at least a secondary education (1.8-4.8) or if the woman had been exposed to the radio, television or print media in the past week (2.4-3.3).

In a multivariate analysis that controlled for other social and demographic covariates, the relationships between women's au-

tonomy and men's involvement in maternal health care were generally similar to those in the bivariate analysis. The likelihood of having discussed the woman's health during pregnancy remained negatively associated with wives' involvement in economic and domestic decision making (odds ratios, 0.8 and 0.5, respectively), and positively related to spousal communication (2.0). Both domestic and movement autonomy were negatively associated with husbands' presence during antenatal care (0.7 and 0.6), while spousal communication was positively associated with husband's birth preparedness and presence at delivery (1.6 and 1.3).

According to the authors, these findings suggest that communication between spouses may enhance both women's autonomy and men's involvement in maternal health care. The negative relationship between other forms of autonomy and men's involvement presents a mixed picture, however, and suggests that a rise in women's autonomy may not be accompanied by greater spousal involvement in maternal care. The authors recommend that policies to improve maternal health "combine a continuous effort to enhance women's autonomy through education and economic support with stimulating husbands' involvement in their wives' health care."—H. Ball

REFERENCE


Levels of Risky Sex Did Not Rise When HIV Therapy Was Initiated in KwaZulu-Natal

Levels of unsafe sexual behavior did not increase when antiretroviral therapy became available in a rural region of KwaZulu-Natal, South Africa, and in some regards residents' sexual behavior became safer, according to an analysis of seven years of surveillance data.1 For example, from 2005 to 2011, the proportion of adults who reported having used a condom the last time they had sex with their regular partner rose by an average of 2.6 percentage points annually among men and by 4.1 points annually among women; increases were apparent among both HIV-positive respondents and those who were uninfected. Moreover, the proportion of respondents