Contraceptive Practice in Quirino Province, Philippines

Experiences of Side Effects

MEASURE *DHS+*

Contraceptive Practice in Quirino Province, Philippines: Experiences of Side Effects

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The NDHS further analysis project is part of the MEASURE *DHS+* program which is designed to collect, analyze, and disseminate data on fertility, family planning, and maternal and child health. Additional information about the MEASURE *DHS+* program may be obtained by writing to:

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Summary

This study examines the contraceptive practices and understandings of women in Quirino Province, Philippines that have led many women to discontinue use of contraception even though they do not wish to become pregnant. This qualitative research study was initiated in response to the high rate of contraceptive discontinuation reported in the 1998 Philippines National Demographic and Health Survey. The results indicate that two in five contraceptive users discontinue use within the first year. Three factors are examined for their impact on contraceptive use behavior: occurrence of side effects, spousal relations, and quality of care.

Methods: The methods used in the study included semi-structured interviews with 81 married women selected from clinic records at the four study clinics. The clinic records for these women were also obtained. Twenty-four of the women were interviewed a second time, in-depth, along with their husbands. Twenty providers including midwives, hilots, and barangay health workers (BHW) were interviewed in-depth. Forty-seven client-provider interactions between midwives and clients and between BHWs and clients were tape-recorded, and a rapid assessment of the study clinics was conducted. Pharmacies in the local area were visited to determine which contraceptives were available, and the pharmacists were interviewed. Finally, the preliminary findings were presented at provider roundtables in the study area to obtain feedback on the study results and to develop a list of recommendations. All interviews and client-provider interactions were tape-recorded and transcribed. The data were collected between May and July 2000.

Findings: According to Quirino women, menstruation helps to keep women healthy. They view menstruation as important for good blood circulation and for keeping the bodily humors in balance. An increase in menstruation is more acceptable to them than a decrease, such as that associated with use of hormonal methods. *Hiyang,* the Filippino concept referring to "suitability," is used by women and men to explain why a pharmaceutical contraceptive method is or is not effective for them. The physical signs most likely to result in a positive *hiyang* assessment are continuation of normal menstruation, weight gain, and absence of symptoms of "high blood" such as headache, dizziness, and hotheadedness. Menstrual changes lead women to speculate about the accumulation of blood in the body and its relationship to "high blood" and, to a lesser extent, "low blood" and other chronic conditions such as tumors or cancer. Women who use the IUD tend to experience fewer side effects and thus speculate far less about their method. The nature of the uterus, rather than the qualities of blood, is the main reason women coose not to use the IUD. Although women usually select the method used, husbands participate in the speculation about the relation between use of contraceptive methods and amenorrhea and hotheadedness.

Women and couples use all available methods of contraception to prevent pregnancy including withdrawal, periodic abstinence, and lactational amenorrhea. Although government family planning clinics are the main source of family planning, people also use private doctors and pharmacies to obtain contraceptive methods. Pills are the most commonly used method, and many women have used the pill continuously for many years. The difference in the responses of women who have used the pill for long periods and those who have used it for short periods is

that long-term users report minimal changes in menstruation and few other side effects. Thus, women who are able to use the pill long term are more *hiyang* with the method.

The results of the study indicate that women in Quirino province use some contraceptive methods in ways not recommended by biomedical practitioners. Women's use of DMPA is determined by their physical response to the hormonal method. When use of DMPA results in amenorrhea, women simply stop using the method until menstruation returns and then go back to their provider for another injection. Another strategy involves switching to the pill when they become amenorrheic on DMPA. Once menstruation resumes, some women continue using the pill while others switch back to DMPA because "it helps them maintain good body weight." Concepts about "high blood" versus "hypertension" can also result in misunderstandings that affect the way women take contraceptive pills and iron supplements.

To varying degrees, midwives and BHWs work with two kinds of knowledge about the body, health, and illness on the job—one biomedical, the other humoral. One is promoted through midwifery schooling, BHW training, and is supported by biomedical knowledge of the body and pharmaceuticals. The other is cultivated through the experiences of women, hilots, and other community members in Quirino province. The two kinds of knowledge do not agree on the meaning of the physical manifestation of menstruation and its impact on health. Nor do they agree on the type and frequency of side effects of pharmaceutical contraceptive methods. In addition, the long-term health concerns of women regarding method use, such as "high blood," are often confused with hypertension in clinic interactions, particularly in the reading of blood pressures. The biomedical orientation of providers can be seen in the client-provider discussions, which reveal that the midwives believe that sexual dysfunction and weight gain are not "real" side effects but rather "psychological" ones. Not surprisingly, midwives reported that counseling women that menstrual changes are normal is fairly ineffective. Midwives sometimes use humoral ideas to convince women to use a particular method; however, the strategy is potentially counter-productive when it does not predict likely physical outcomes.

Conclusions: The Quirino study shows that contraceptive use behavior can be influenced by the sociocultural context. Women's understandings about health and the suitability of using a particular contraceptive method are not simply a matter of the safety and efficacy of the method. They also include whether the method "fits" them personally or improves their quality of life and relationships. This is reflected in the Quirino concept of *hiyang*, suitability.

Cultural differences in the social construction of the biomedical and humoral body and the bicultural position of the midwives and BHWs make difficult the provision of the pharmaceutical methods currently on the market. In opposition to biomedical common sense and much of the family planning literature, which promotes a decrease in menstruation as an "advantage," Quirino women regard an increase in menstruation as healthier than a decrease. Because of the differences in biomedical and humoral perspectives of the body and relations between provider and client in the clinic, a significant number of women develop contraceptive strategies that expose them to pregnancy long after the assumed adjustment period has ended.

Recommendations: Training, planning, and management and counseling on side effects are needed.

The bicultural position of health-care providers should be addressed in midwife training, medical education, and ongoing professional training.

- The training of midwives, doctors, and public health nurses might incorporate modules on alternative perspectives of the body, how to show respect for differences, and how to negotiate treatment options. This type of module might include discussions designed to sort out the differences between biological and humoral views of the body, health, and illness, and their significance in women's lives. The training might also include practical skills for eliciting the client's perspective on the body, identifying areas where the client's perspectives differ from those of the provider, and negotiating treatment options.

- Training of midwives might include information on the incidence of biological side effects of the methods derived from clinical trials as well as the understanding that the incidence varies depending on the characteristics of the group serving as subjects in clinical trials.

The method-mix at clinics should have sufficient variety that midwives do not feel pressured to convince women to use a particular method, when the method may not be well suited to their needs.

- Consider offering diaphragms, several brands of oral contraceptives, and emergency contraception through government family planning clinics or partnering institutions.

- Consider providing the 100mg dose of DMPA rather than the 150mg dose of DMPA through the government clinics.

- Consider providing biologically based information on the use of natural methods such as periodic abstinence and withdrawal since many couples use them.

Counseling and health education should be geared more closely to the actual experiences of women.

- The counseling portion of the *Family Planning Clinical Standards Manual* and family planning training could be modified to reflect an underlying respect for women's views on the body and how to communicate this respect to the client through actions. The following counseling principles might show how best to negotiate the two sets of assumptions (biomedical and humoral) about the body and health for the best client outcome.

    a) Treat women's experiences as fact: If a woman says she has a side effect from a method, it does not matter whether it is biological, social, cultural, psychological, or political. It still needs to be heard, discussed, and addressed in the treatment plan.

    b) Switching is not a bad thing: Clients should be provided with the option of switching methods that cause side effects such as undesirable weight gain, sexual dysfunction, headaches, dizziness, or amenorrhea. Clients who switch methods under the guidance of a provider will be more likely to continue using contraception.

c) Counseling on side effects is ongoing: Counseling on side effects prior to dispensing a method is important. Perhaps more important, however, is talking to the client about side effects when they have used a method for at least a month. After experiencing side effects, women are often more open to learning about the correct way to use specific contraceptive methods.

d) Focus on manifest effects: Negotiation of method choice should take place in a context of consideration of the manifest effects of methods, such as menstrual bleeding, rather than according to which theory of the body is viewed as "correct."

- The health education pamphlets produced by UNFPA and distributed through government family planning clinics might add decreased libido and coital dryness to the list of possible side effects of DMPA and oral contraceptives. The pamphlets could also describe what to do if side effects are experienced.