Chapter 2

Methods

2.1 Locating the Study within the Philippines

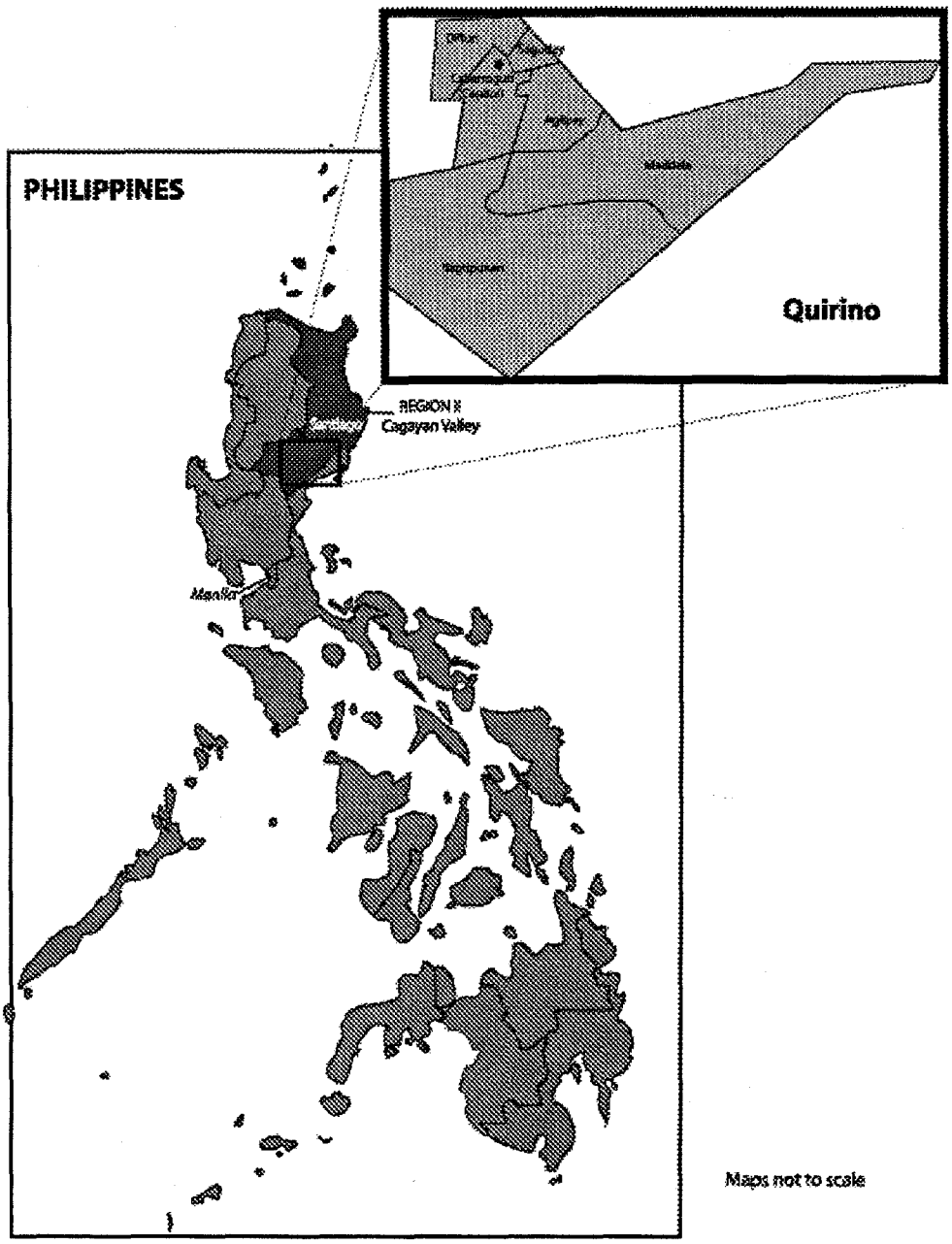
Quirino Province on the island of Luzon was chosen as the site for this study because Quirino was likely to have a high concentration of people with the types of experiences of interest to the investigation. The results from the 1998 data showed that Region II (Cagayan Valley) had the highest rate of discontinuation of contraceptive methods in the country due to side effects and health concerns.[2] Students from the University of the Philippines Population Institute (UPPI) performed some further analysis of the 1998 DHS data from Region II that showed Quirino Province to have not only the highest contraceptive prevalence rate but also the broadest use of methods. Quirino, in other words, stood out among the other provinces of Region II as likely to have the most people with the type of experiences the study wished to investigate.

2.2 Quirino Province

Quirino Province lies in the southeastern portion of Cagayan Valley. It is bounded by the provinces of Isabela in the north, Aurora on the east and southeast, and Nueva Vizcaya on the west and southwest. The most recent census of the province showed the ethnic composition of Quirino to be 74 percent Ilocano, 14 percent Ifugao, and the rest Igorots, Calingas, Bucalots, and Tagalog (NSO, 1995). The province has an aggregate land area of 305,718 hectares, representing 1.02 percent of the total land area of the country. Six municipalities comprise the province of Quirino: Cabarroguis, Diffun, Aglipay, Maddela, Nagtipunan, and Saguday. Cabarroguis is the capital town, while Diffun, which is contiguous with Santiago City in Isabela, is the commercial center.

The dominant ethnic group in the area is the Ilocano, who speak a language related to Malay. There is also a significant population of Ifugao, a minority tribal group found in higher concentrations in more isolated parts of the province. Although Ilocano is the most common first language in the area, many, if not most, people are multilingual, speaking Ilocano, Tagalog, Ifugao, and Igorot.

[2] The discontinuation rates due to side effects and health concerns are 5 percent higher in Region II than in any other Philippine region (NSO, DOH, MI, 1999).


PHILIPPINES
REGION II
Cagayan Valley
Manila
Quirino
Maps not to scale

In terms of the health needs of the people, the province has one provincial hospital and a number of private hospitals and clinics. Most people, however, rely on the rural health units or barangay health centers for their health care needs. Municipal health centers usually have a medical doctor, a nurse, a health inspector, a medical technologist, a midwife, and volunteer health workers. In small barangays, a midwife is in charge of the barangay health station with the help of barangay health workers. In a devolved system, municipal health units are under the local government, while the barangay council oversees the barangay health stations. In some areas, barangay health workers receive salaries provided by the barangay council. The government clinics provide services free of charge although some clinics ask clients for a donation for the upkeep of the clinic. Traditional midwives called hilots living in the area also perform family planning activities such as delivering babies and treating women for infertility.

2.3 Clinic Study Sites

Through discussions with both the regional and provincial Population Commission administrators as well as the Quirino provincial medical director, it was decided that a mix of rural, urban, and migrant areas would yield a full picture of contraceptive practice in the province. The study was conducted in a mix of three of the municipalities meeting this criterion. Saguday, primarily a farming and rural municipality, was experiencing high unemployment at the time of the study, and many adults were moving in and out to take domestic and labor jobs in other regions and countries. Diffun, the commercial center, was included because it represented the most urban population in Quirino Province. Cabarroguis, where the provincial hospital was located, was the most diverse municipality, containing both hard-to-reach minority farming communities as well as a more urban population living in the town of Cabarroguis.

Each municipality in Quirino Province has a central municipal health unit that serves a number of barangay health stations (barangay is the smallest governmental unit) staffed by midwives and health workers. Four health clinics were chosen as the clinical study sites: the Saguday rural health station, the Diffun municipal health station, and two health stations in Cabarroguis—Zamora (because it was more centrally located) and Debibi (because it was located in a far-flung Ifugao community). Debibi was more difficult to reach due to poor roads; during the rainy season, it is cut off for the most part from Cabarroguis (see Table 1 for study clinics).

Midwives are the primary providers of family planning in Quirino, and they see clients in the clinic. BHWs are volunteers that can provide resupplies of pills and condoms to people in their neighborhood as well as counseling on an as-needed basis. The modern contraceptive methods provided through the Saguday, Diffun, Debibi, and Zamora clinics included oral combined contraceptive pills, IUDs, DMPA three-month injections, condoms, tubal ligation, and vasectomy. Clients requesting sterilization are given a referral to the hospital and all other services are provided at the family planning clinic. Clinic midwives do not provide information on the natural or traditional methods such as calendar/rhythm method/periodic abstinence, mucus/Billings/ovulation, basal body temperature, symptothermal, lactational amenorrhea method, breastfeeding, and withdrawal unless they are specifically asked to do so by clients.

Table 1. Municipality, health stations, and study clinics

Municipality	Number of health clinics	Study clinics
Cabarroguis	1 Municipal health station 5 Barangay health stations	Municipal health station Debibi rural health station
Diffun	1 Municipal health station 4 Barangay health stations	Municipal health station
Saguday	1 Municipal health station 3 Barangay health stations	Rural health station

2.4 Staff Recruitment and Training

The study team was recruited through the University of La Salette. Several faculty members were recruited to work on the study, which took place for the most part during the summer break. Two La Salette faculty members directed the data-gathering process, one during phase I and another during phase II. Three interviewers were recruited through the university, one faculty member and two graduates of the university. A fourth woman, an unemployed teacher from an Ifugao area, was also recruited as an interviewer, bringing the total to four interviewers. In addition, two demography masters students from UPPI assisted with the sampling, facility assessments, interviewing, and translation of the interviews. They, along with University of La Salette staff, provided computer support and training to the other interviewers.

The team had three days of classroom training and two days of fieldwork practice conducted by a Macro International Inc. staff person. The team was presented with the project plan and purpose and was taught basic interviewing skills during the classroom training, which they later practiced in the field. The interview guides used to interview participants were pretested and finalized during the five-day training and fieldwork practice.

2.5 Study Overview

Several field methods were used to gather the study data from married women, couples, and the providers who serve them during two phases of fieldwork. The central method was to conduct semistructured interviews with 81 married women who were selected from clinic records at the four study clinics (see participant recruitment for selection and recruitment procedures). Information from clinic records was also collected with the permission of the women. Twenty-four of these women were interviewed again, in-depth, along with their husband. Some of the 81 married women interviewed were also BHWs. These participants should not be confused with the sample of BHWs that were interviewed about their work as a BHW (see below).

Data on clinic practice was also gathered. Twenty providers including midwives, hilots, and BHWs were interviewed in-depth. In addition, 47 client-provider interactions between midwives and clients and BHWs and clients were tape-recorded, and a rapid assessment of the study clinics was also conducted. Pharmacies in the local area were visited to assess the contraceptives available, and the pharmacists were briefly interviewed.

Finally, the preliminary data were brought to roundtables of providers in the study area for feedback and generation of recommendations.

2.6 Phases of Data Gathering and Interviewing

The data was gathered in two phases of approximately four weeks each, with a review period of two weeks between the first and second phase. In the first phase, interviews were conducted with 81 women individually. In the second phase, 24 interviews with couples were conducted.

Phase I

During phase I, semistructured interviews were conducted with 81 female current and past users of contraception, 20 from each of the 4 study areas: Saguday, Diffun, Debibi, and Zamora. The interviews with 81 women included a contraceptive history told with minimal interruption from the interviewer, as well as questions about fertility and menstrual practice. If crucial elements of the history were not mentioned spontaneously by the participant, such as time passed between stopping a method and beginning a new one, the participant was prompted by the interviewer to provide those specific details. In addition, with the permission of the women, we collected all available clinic family planning records on the study participants.

Participant Recruitment and Sample of Married Women

The sample of 81 married women was composed of past and current users (including new acceptors) of modern contraceptive methods including the pill, DMPA, IUD, and condoms (see Table 2). The following sampling and recruitment procedures were used to select study participants.

Past users: At each of the four study clinics, the names of all the women who had been lost to follow-up were compiled. Lost to follow-up was defined as being at least two months overdue for a follow-up clinic visit for a temporary modern method of contraception, i.e., the pill, IUD, injectables, and condoms. Every third woman on the list was visited at her home by a midwife, read a consent form, and asked to participate in the study until 40 women meeting the study criteria had agreed and been interviewed (10 from each of the 4 clinic sites).

Current users: At each of the four study clinics, two lists of current users of temporary methods of contraception were also compiled. One list contained the names of women who had used a method for more than nine months and the other list contained the names of women who had

started using a method in the last one to three months. Women were recruited from these lists in the same manner, by choosing every third woman until 40 women had agreed and been interviewed (10 from each clinic site, including 5 new acceptors from each site).

Table 2. Use of contraception by women in study sample

Municipality	Number of current users: New acceptors	Number of current users: Ongoing users	Number of past users	Number of women
Cabarroguis	5	5	10	40
(Debibi)	5	5	10	
Diffun	5	5	10	20
Saguday	5	5	11	21
Total	–40–		41	81

The ethnic composition of the final sample of 81 women was as follows: 54 Ilocano; 10 Ifugao; 9 mixed Ilocano with Ifugao, Igorot, Tagalog, Ibaloi, or Pampaguena; 3 Igorot; 3 Tagalog; 1 Visaya. The participating married women were literate, and about half lived in rural and half in urban settings in Quirino Province. The urban settings in Quirino are more comparable to a small town setting than a metropolis such as Manila. The married women ranged from 18 to 46 years of age. For details on age, number of children, and ideal number of children of participating women please see Appendix.

Providers

Twenty providers, including seven midwives, one physician, eight barangay health workers, and four hilots, were also interviewed during this phase (see Table 3). Providers were interviewed about services, clinical guidelines, contraceptive side effects, understandings of physiology, partner relations, and the causes of discontinuation and clinic effectiveness.

Forty-seven client-provider interviews, some between midwives and clients and some between BHWs and clients, were tape-recorded. Three midwives were given tape recorders and directed to tape ten interviews with clients including new acceptors. The tape recorders were given to BHWs in each of the three municipalities, and they also taped five interviews with clients. Various types of visits were recorded including 15 pill, 8 DMPA, and 2 condom resupply visits and 1 IUD removal. New client visits (either switchers or new to any method) were also recorded, including seven oral contraceptives and one IUD insertion. One woman came in for infertility problems as well. The remaining were BHW visits for resupply.

Break

During the two-week break the contraceptive histories of women were compiled, and general themes were identified and incorporated into the phase II in-depth interview guide. In addition, a subsample of couples was chosen. The subsample was chosen based on the likelihood they would be able to provide further clarification of themes that emerged from the phase I data. We visited the pharmacies located in the study area to assess the contraceptive methods available and to briefly interview the pharmacists.

Phase II

During phase II, follow-up interviews were conducted with 25 couples drawn from the sample of 81 women.[3] Building on the contraceptive histories obtained during phase I, the open-ended interviews during phase II explored themes that emerged from that data in further depth as well as the couple's experience prior to contraceptive decisionmaking points. In addition, the husband's knowledge of and perspectives on use of contraception and the various methods, including his experience with male methods, was explored during these interviews. Neighborhood pharmacies were visited to learn what contraceptives were available and what counseling was provided at the pharmacies.

Table 3. Sample of couples and providers

Municipality	Number of couples	Number of providers[1]
Cabarroguis	7	6
Diffun	8	7
Saguday	8	7
Total	24	20

[1]Midwives, barangay health workers, and hilots

All interviews were taped and translated into English with all efforts made to represent a direct translation of the spoken words. The Ethnograph software program was used to code and compile responses. Oral permission was obtained from all participants, including clinic staff and clients.

[3] Several of those identified for reinterview refused to be reinterviewed when the interviewer went to their house The main reason was that the rainy season started at the juncture of phase I and II Since this is the best time to sow the field, they wanted to take advantage of the weather

A roundtable session with providers, study team members, administrators, and community members was conducted after completion of the preliminary report. More than 35 midwives and BHWs from the study areas attended the presentation and roundtable. Those present were asked to comment on the accuracy of the interpretation; to discuss the quality of care, the main counseling issue that emerged from the fieldwork data; and to participate in generating recommendations for improving services. This input was included in this report in the same manner as the other data.