Chapter 5

Strategies for Preventing Pregnancy: Balancing Contraception and Good Health

This chapter focuses on the strategies women used to prevent pregnancy. Women as a collective used all of the methods available to them in their local setting to prevent pregnancy. [11] In addition to the four temporary methods distributed through the government health clinics, a significant number of participants said they used other methods. For example, withdrawal, periodic abstinence, and LAM were mentioned by some couples, several of whom said they had used the "natural" methods very effectively to prevent pregnancy over a period of years. Withdrawal was the most common, used either as an initial method or as a temporary method before switching to another pharmaceutical method. Some participants said that they had used local pharmacies to buy other brands of pills and other contraceptive supplies, thereby increasing their method choices. At least two kinds of alternative low-dose oral contraceptive pills are sold widely and ranged in price from P13 to P360, including the popular Femenal for P80 to P97 and Trust Pill for P13 to P22. Diffun pharmacies had six different brands of low-dose contraceptive pills available. In addition, these pharmacies sold Depo-Provera contraceptive injections, including the syringe, and a variety of brands of condoms. Some women found these pills of higher quality for example, Morie said,

> *"But there were times that I have to buy so I can have pills which are of better quality . . . Feminal, that is a good pill; I didn't grow so thin."*

The pharmacists generally said that they do not counsel women on side effects in the pharmacy when the medications are sold nor do they always ask women whether they are married before selling the supplies.

When asked why they chose their first pharmaceutical method of contraception, women often gave general answers. For example, "I heard it was good from a friend," "I wanted to provide a better life for [or spacing between] my children," "it was convenient and popular," or "the doctor recommended it." The reasons given for stopping the method were nearly always related to the side effects experienced by the woman.

When women who did not wish to become pregnant stopped using a pharmaceutical contraceptive method, whether obtained at a government or private clinic or a pharmacy, most of the time, it was done to counteract or prevent the potential health consequences of using the methods. Several women, however, said that lack of supplies or the distance to the clinic caused them to discontinue a method at one point in their reproductive career. Women who lived apart from their husband either because they or their husband worked for extended periods either in other locations in the Philippines or overseas, said they would stop using their method when living apart from their husband. They were vulnerable to pregnancy either because they

[11] Because the study sample was chosen from clinical records, it may not represent the entire range of strategies used in the community but rather those of women who rely, at least in part, on government family planning clinics.

discontinued the IUD before they actually were sleeping apart from their husband or because they were not using contraception when reunited with their husband.

The 1999 local government performance survey showed that in Quirino Province 48 percent of married contraceptive users used pills, 22 percent used injectables, 11 percent used IUDs, and 3 percent used condoms (Padua, 1999). Table 7 shows that from our small sample, 34 out of 44 DMPA users, 25 out of 56 pill users, 7 out of 28 IUD users, and 11 of 11 condom users discontinued the method before 1 year of use the first time they used a method.

Table 7: Study participants discontinuing before one year of use

Contraceptive method	Number of discontinuations	Number of women
DMPA	34	44
Pill	25	56
IUD	7	28
Condom	11	11

Rather than abandoning contraception altogether women often switched between the various methods available at the government health clinics and pharmacies and "natural" methods such as withdrawal and periodic abstinence. Some women switched methods frequently for a period of years, then used a method consistently for several years in a row, and then began switching between methods before one year of use again. Given this reality, it makes little sense to try to determine a "type" of woman who is likely to discontinue using contraception or who is likely to continue using contraception. Rather, it makes more sense to look at the strategies women used to keep from becoming pregnant, and within these, contrast episodes of long-term use with episodes of short-term use or discontinuation for reasons not related to pregnancy.

Several examples are presented below to illustrate how couples' experiences with and speculation about contraceptive methods (discussed in the last chapter) figure into their ongoing strategies for preventing pregnancy.

5.1 Using DMPA in Response to Body

Of the women who used DMPA, 34 out of 44 said they had significant changes in their menstruation and 24 out of 44 experienced amenorrhea with DMPA use. It was interesting that women who did experience amenorrhea but who liked DMPA otherwise were able to reconcile the health risks of the method sometimes by getting their shots less than once every three months.

For example Elsie, a barangay health worker with three children, explained how she took DMPA:

> *"When I had my injection, for example, today, then next month, I don't have my period. For almost nine months, I did not menstruate."*

When the interviewer asked,

> *"Did you go back every three months to have your injection?"*

She responded,

> *"No, because after my first injection, I didn't go back for my second injection. It took me almost a year to go back because I waited for my menstruation first. When I got back my menstruation, that's the time I went back for my second shot."[BHW]*

Florida, who used the same strategy, reported an even longer period of amenorrhea after the injection of a 150 mg standard dose of DMPA, saying,

> *"After I used depo for one year, I didn't menstruate for two years . . . After two years, I had my menstruation, then I went to the midwife for another injection."*

When asked why she waited so long, she said,

> *"Because I had no menstruation yet . . . then (after discontinuing) I had my monthly period regularly for the dirty blood to come out. After that, I went back to depo again."*

Ten of the women we interviewed who had tried DMPA said they experienced anywhere from six months to two years of amenorrhea after discontinuing the method. A significant number of participants used the strategy of waiting until they menstruated to go for another shot. The medical records of women who reported long-term use (from two to five years) of DMPA showed that they actually on average received a little more than two shots of DMPA per year rather than the prescribed four. Although they did not consider this discontinuation, a provider presumably would. Some women said they were protected from pregnancy as long as they did not menstruate. Some women even said that they were advised by providers to stop using DMPA when they became amenorrheic, and indeed, this was charted on some medical records as "dropped due to amenorrhea to give way for menstruation."

Feli, for example, said she stopped taking DMPA after her fourth DMPA shot at the advice of the midwife:

> *"I was suppose to get another shot in August, but the midwife wants me to stop . . . She advised me to stop for a while until I get my period back."*

Erlinda, another participant, explained why she did not need to get DMPA every three months:

"The midwife told me that if you have a weak immune system, then the duration of the effect of depo takes about one year."

Some women were willing to accept the risks associated with use of the methods, such as amenorrhea, for certain periods of time. For example, Ursula felt she was *hiyang* with DMPA. When asked whether the loss of her period bothered her, she responded,

"Yes, because I would like to have my menstruation even if only once every two months."

Ursula decided to stop using the method after 11 months. Like other participants, she was willing to risk the effects of no menstruation for limited periods of time, which ranged upward from two months but rarely exceeded one year.

It's not surprising that some women tried other means to bring on menstruation when experiencing DMPA-induced amenorrhea, such as Coca-Cola douche, over-the-counter medicines, or herbal medicines. For example, Josie from Debibi recounted a treatment received from a hilot after using DMPA as follows:

"Supposed to be, I have to let it be massaged every now and then so that the blood clot will be removed. It might be the effect of using depo, which I did not menstruate for so long . . . [Auntie], she said it might be the effect of cold only or a vein exposed to too much cold . . . because I never menstruated since then [using depo], and the blood that was supposed to come out was accumulated in my uterus."

Although a few attempted to induce menstruation while on DMPA, most of the women simply stopped the method until their menstruation returned.

A BHW reflecting on ways to improve clinic services included ways to address side effects as a positive option:

"In order that the services will improve, I want an additional medicine to counteract side effects, especially for those clients that are not comfortable with the method, like Rizza. If she will take the pills, she will have an allergy, but if she will buy the pills outside, she will be comfortable with the other brand of pills, but it was very expensive. We have a lot of women using contraception in our purdok (neighborhood). Anyway, there's a lot of contraceptive methods, and we can choose from those."

5.2 Switching from DMPA to Pills and Back Again

Another strategy to counteract the loss of menstruation with DMPA was to alternate between DMPA and pills. Georgia, for example, explained her response to the methods as follows:

"With pills, I have my menstruation but in little flow only; I have it for three days. With depo, I never had my menstruation."

She went on to explain how she coped with her response to these methods:

> *"So what I did was I use pills and depo alternately . . . when I had my depo and the injection was good for three months. After that, I take pills also for a month so that I will have my menstruation. After getting back my menstruation, I will have again my injection. Then I will do the same again."*

When asked by the interviewer,

> *"Why did you want your menstruation back?*

She, like the others, responded,

> *"So that the dirt inside our body will come out, especially when you have illness and you don't have your menstruation, then you will not feel good."*

Her particular strategy involved buying the DMPA from the market and self-injecting it and getting supplies of condoms and pills from the family planning clinic. Although DMPA was used repeatedly in some cases, it was usually used for less than a year at a time. These patterns account for some of the difficulty women had in recalling and explaining to interviewers exactly when they started and stopped using a method of contraception.

5.3 Using Pills as Primary Strategy

Pills are the most commonly used method, and many women used them consistently for long stretches of time, many up to five years and beyond, and up to ten years in one case. The difference in the responses of women who used the pill long term from those who used it more briefly was that long-term users reported a minimal change in their menstruation and few other side effects. In other words, the women who used the method long term were more *hiyang* with the method.

A few of the women who reported long-term use of the pill actually used the method inconsistently. For example, only when their husband was home, as discussed in chapter 4. A number of the women who used the pill over the long term had used DMPA first.

For example, Josie, a BHW with seven children, used pills for several years. She had a chronic health condition and thus saw a private physician for all her health care needs including contraception. During an interview with her and her husband after reflections were made by the husband and wife about their decisions about switching contraceptive methods. Josie said,

> *"After [my first] shot of depo from my doctor I did not have my menstruation, but still I went back for the next shot, and I asked X why I did not menstruate. She told me, 'just continue using it and you will have your menstruation soon' . . . She told me that I can take pills if I want and that if I will use pills, then I will menstruate. But I told her that*

depo is better because I became fat when I used it. Actually, I was very thin before. She asked me what I want—to continue depo or take pills. I chose to continue depo."

She still did not menstruate after the second shot and thus returned to the doctor again to seek advice. She said the following about that visit:

"That's the time we went to Dr. X and discussed with her why I never had my menstruation. She answered, 'don't worry,' and she asked me, 'how do you feel?' I told her that I experienced headache sometimes. She advised me to use pills so that I will have my monthly period for at least two to three months, then I just go back for my injection of depo again. But when I observed that I am comfortable with pills, I never went back for another injection of depo. My menstruation became regular."

Her husband then reflected on DMPA, saying,

"But the problem was she never had her menstruation and she became hot-tempered and irritable, so I told her to stop the method because she might get high blood pressure."

The wife confirmed his observations about her reaction to DMPA:

"My blood pressure was 130/80". . . I was irritated and hot-tempered . . . They advised me to avoid sleeping always and avoid eating camote . . . When I stopped using the method [DMPA], it all went back to normal."[BHW]

It is interesting that rather than simply telling the client not to worry about her loss of menstruation, the doctor negotiated with the client and gave her the choice of another method to relieve the side effect she was experiencing.

When asked why they stopped using the pill after using it for several years, women gave various types of answers. Usually it was because there was some significant change in their health status, such as getting a urinary-tract infection (UTI) or having malaria; because they were simply tired of taking it; or because they decided to try DMPA to gain weight.

5.4 Using the IUD

As was described in the last chapter, women were hesitant to choose the IUD because it was seen as not so practical for women who had to work hard in the fields on a regular basis because the IUD might fall out during menstruation. Two study participants actually experienced dislodging of the IUD, and they simply had it replaced. Some of the reasons for choosing the IUD were hypertension and the desire to have normal menstruation. Another IUD user switched from the IUD to pills every three to four years because she wanted to gain weight. She explained,

"I wanted to become fat and gain weight because I was thin when my husband went abroad . . . but when I became fat, I shifted again to IUD"

The participants who accepted the IUD either had it removed before one year due to side effects including increased bleeding, as three study participants did, or they kept it over a period of years, usually more than five and up to seven. One woman had the IUD removed because she planned to work away from her husband in Taiwan but then got pregnant before she left.

The women who used an IUD from five to seven years and had it removed because the IUD had "expired" usually did not have a new one placed immediately but rather took a "rest" from the IUD. Some tried a hormonal method during the rest period. This was the typical experience. On the other hand, one of the women who had her IUD removed after a year of use said the following about her experiences with the method:

> *"I experienced the negative effects after one year of using it. I felt hypogastric pain for one month; the pain became severe during sexual intercourse and when I go to our rice field . . . Yes, I discussed with him [husband] that I experienced hypogastric pain, and I had a profuse menstruation for ten days. I told him that I am not comfortable with the method; I always experienced pain during our sexual contact and even without our contact."*

The provider at the center prescribed ferrous sulfate but eventually she had the IUD removed. She attributed her problem with the IUD to her spending too much time in the rice fields, where she was subjected to dampness and cold.

Women used every method of contraception at their disposal to prevent pregnancy. Although the government family planning clinics were their main source of services, they also used private doctors and pharmacies to obtain contraceptive methods.
Women increased their ability to prevent pregnancy by using contraceptive methods in ways not usually recommended by biomedical practitioners.

The first was using DMPA according to bodily response. When DMPA caused amenorrhea, women simply stopped the method until their menstruation returned and then returned for another injection. This amounted to a compromise between staying healthy and preventing pregnancy. The extent to which this strategy resulted in unwanted pregnancies is unclear. Another strategy involved switching to pills once becoming amenorrheic on DMPA. Once menstruation resumed, some women continued using pills, and others switched back to DMPA because it helped them maintain good body weight. The same strategy was used in the opposite direction depending on the bodily effect of pills and DMPA on weight and appetite.

Many women did not use the IUD as their first choice of method. Some eventually used it because they were not able to use any of the hormonal methods due to high blood pressure. This method was rejected for its impracticality since they were told not to work too hard while using the IUD (including by midwives) and because it was thought to increase the exposure of the uterus to cold by holding the uterus open. This opening effect of the IUD was also said to be one reason for increased menstruation while using the IUD.

The next chapter examines some provider strategies for managing these patters of contraceptive use.