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

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Chapter 1

Introduction

This qualitative study funded by the United States Agency for International Development (USAID) examines the socio-cultural processes that lead Filipino women to discontinue using methods of contraception even though they do not wish to become pregnant. Specifically, it examines how socio-cultural constructions of the body, health and illness, spousal roles and relations, and the quality of family planning services figure into the contraceptive practices of married women living in Quirino Province, Philippines. The study was initiated in response to the high rates of contraceptive discontinuation found in the 1998 Demographic Health Survey (DHS) where two in five contraceptive users in the Philippines discontinued use within the first year (NSO et al: 1999).

Studies of family planning in the Philippines suggest that both side effects or health concerns and spousal relations are central to discontinuing the use of a contraceptive method. Of the Filipino women who discontinued a modern method of contraception, 37% of pill users, 49% of IUD users, and 59% of injection users said they stopped using the method because of undesirable side effects and other health concerns (NSO et al: 1999). Although husband's disapproval was cited by only about 3% of women as a reason for discontinuing a method in the 1998 DHS, family planning researchers in the Philippines have found it to be a significant factor contributing to unmet need for contraception. This is true especially in situations where couples disagree over preferences and the attributes of methods (Biddlecom, Casterline, and Perez: 1997; Casterline, Perez, and Biddlecom: 1997).

The modern contraceptive methods promoted by the Population Commission which administers the Philippine federal family planning program include oral combined contraceptive pills, Intrauterine Devise (IUD), depotmedroxyprogesterone acetate (DMPA) three-month injections, condoms, tubal ligation, and vasectomy.[1] The natural and/or traditional methods approved by the commission include calendar/rhythm method/periodic abstinence, mucus/Billings/ovulation, basal body temperature, symptothermal, lactational amenorrhea method (LAM), breastfeeding, and withdrawal. According to the 1998 DHS, female sterilization and the pill are the most preferred methods (10% each), closely followed by withdrawal and the calendar/rhythm rank next (9% each). The IUD is used by 4%, followed by injections and condoms by 2% of women (NSO et al: 1999). The remaining methods have fewer users, each method being used by one percent or less of married women (NSO et al: 1999).

[1] The Philippines federal government currently makes available the means for provincial governments throughout the country to provide free family planning methods to their citizens. Due to local government rules in some provinces, however, the population commission is not able to provide these services. Clinics are not required to promote all methods. In addition, the national family planning program is currently in the process of adding a privatized fee-for-service component designed to accommodate the middle and upper classes. At this time most Filipinos have access to free contraceptive methods.

Modern temporary contraceptive methods developed by pharmaceutical companies, including those used in the Philippines, have a range of biomedically recognized side effects such as headache, weight gain, nausea, depression, cramping, and decreased libido that may make them difficult to use on an ongoing basis for certain individuals. The incidence of side effects of the hormonal methods, such as headache and nausea vary but are generally understood to be more acute during the first few months after initiating a new method. In addition, hormonal methods and IUDs can cause changes in the menstrual cycle such as unpredictable spotting, increased or decreased bleeding, and amenorrhea that can last as long as one continues the method. Based on an assessment of mortality associated with method use Hatcher, an authority on contraceptive technology, states, "In general, contraception poses few serious health risks to users. Moreover, the safety considerations of contraceptive methods are not as great as those of pregnancy-related complications" and methods such as the pill can be used safely throughout one's reproductive years (Hatcher: 1998).

This understanding of the safety of modern contraceptive use and the non-serious nature of the side effects is derived from a biological understanding of the body that is not always shared by those using contraceptive methods. For example, though unintended effects, such as the loss of menstruation with DMPA use or the 60% decrease in menstrual bleeding with use of oral contraceptive pills, may be promoted as menstrual benefits in the clinic (Hatcher: 1998), women worldwide have expressed their desire for an effective contraceptive method that does not change the menstrual cycle (WHO: 1983; Scott:1975: Bongarts and Bruce: 1995). Although menstruation has some degree of biological regularity, the meaning attributed to it and how it figures into women's and men's ideas and practices related to the body, health, and illness expressed in the clinic interaction vary widely throughout the world (Buckley and Gottlieb: 1988).

Contraceptive practice as a whole is highly influenced by socio-cultural understandings and practices related to the body, health, and illness as they are actively constructed and reconstructed in daily life within families, clinics and the community. Bodily experience produced by medications, whether biomedical, traditional, or some other type, are to a significant extent culturally determined as are peoples' interpretations of the efficacy, side effects, safety, and utility of medications. To understand how modern contraceptives are actually used by couples, in other words, one must look beyond the safety and efficacy of the bio-chemistry of the substances to the socio-cultural circumstances and lives of those who use and dispense them (Van Der Geest: 1988).

The client-provider interaction is a key aspect of providing high-quality care (Bongarts and Bruce: 1995), and in family planning it is the chief means for addressing dissatisfaction with contraceptive methods. Often, clients and providers hold substantive and conflicting assumptions about the body, health, and illness. Differences in common sense related to the body and health are often complicated by the traditional roles of clinics that favor the

provider over the client and biomedical theory over clients' experience. These differences affect communication about methods, instructions on using methods, follow-up, understanding of the purpose of medical procedures, and ultimately, choice and use of contraception. Understanding these differences and the way clients use methods can provide planners with information for choosing the most appropriate set of methods to be provided and improving health education and the content of the client-provider interaction.

1.1. Purpose and Study Questions

This study provides a holistic picture of the contraceptive practices in three municipalities of Quirino Province, Philippines, providing insight into how local constructions of the body, spousal roles and relations, and the client-provider interaction figure into these practices. The overall aim is to make recommendations to improve the quality of family planning services, for example, by identifying issues for discussion in the round table with providers, by highlighting some potentially better practices and identifying untoward effects of routine procedures and policy on women's use of contraception.

To examine how people understand and use contraceptive methods one must look to the domains of daily life that a contraceptive method affects. Since the methods are designed to prevent pregnancy (or alter fertility), this is one major area to be explored. This would include menstruation and sexuality since they are a part of fertility and since the methods themselves are known to affect it. In addition, contraceptive practice itself includes how methods are used, the bodily experience and interpretation of methods, and how these experiences develop into long-term strategies for limiting pregnancy. On the clinical side, contraceptive practice includes how the methods are delivered in the clinic, for example, the content of the client provider interactions, the choice of methods offered, and the strategies of providers to create a successful clinic and program.

Overall, the study questions are designed to elicit an understanding of the active strategies used by couples to limit family size and how barangay health workers (BHW) or volunteer health workers, midwives, and hilots (traditional midwives) influence their strategies. The following questions were used to guide the data-gathering process:

- What are women's understandings and daily practices related to menstruation, sexuality, and fertility?
- What physical changes are experienced when using the oral combined pill, intrauterine device, DMPA, and/or condoms?
- How do women, and couples make sense of these physical changes?
- How do women use modern contraceptive methods in daily practice?
- What long-term strategies do couples' and/or women use to prevent unwanted pregnancy?
- How do providers discuss side effects of contraceptive methods with clients?
- What other approaches to counseling might be tried?

Chapter 2

Methods

2.0. Locating the Study within the Philippines

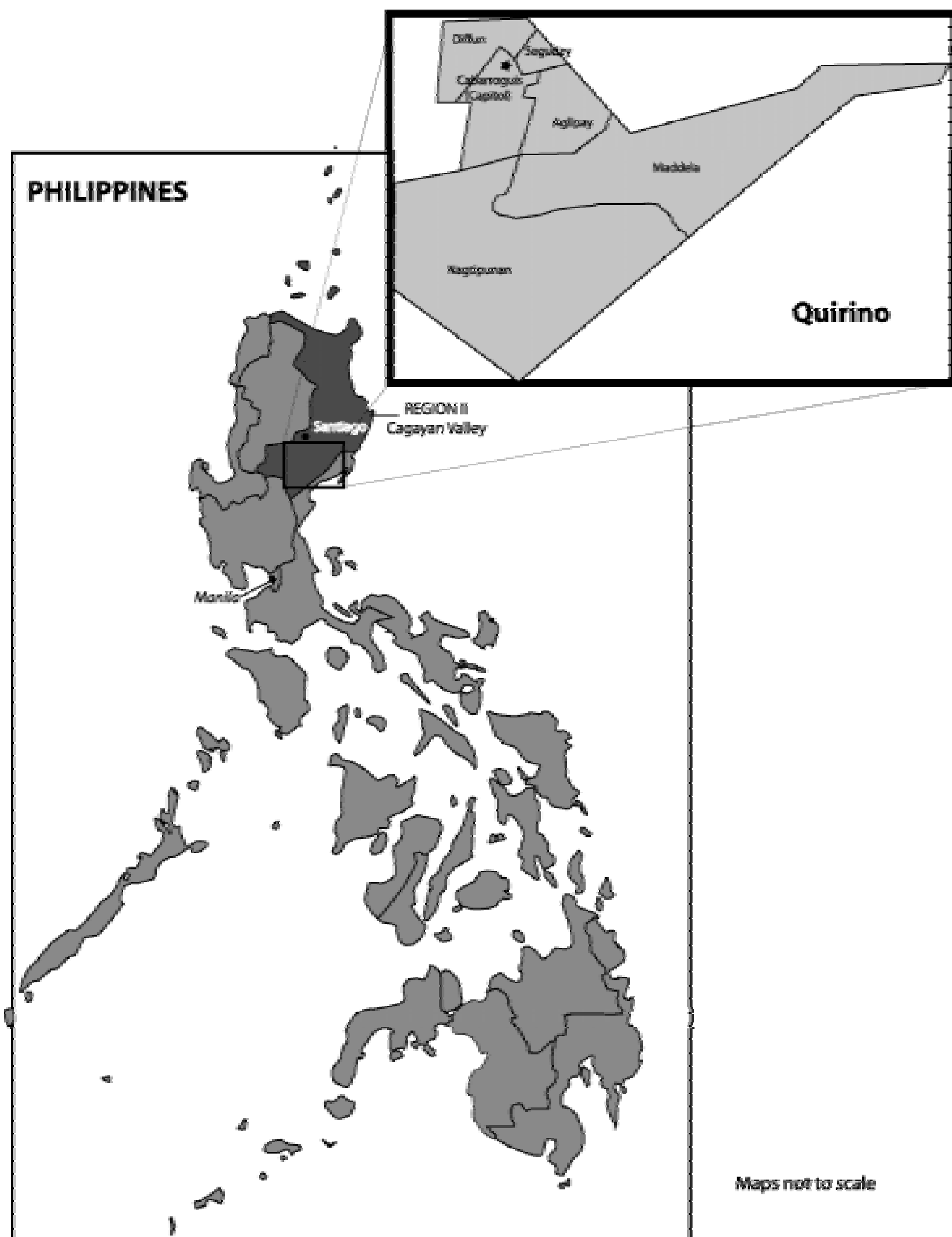
Quirino Province on the Island of Luzon was chosen as the site for this study because Quirino was likely to have a high concentration of people with the types of experiences of interest to the investigation. The results from the 1998 data showed that region II had the highest rate of discontinuation of contraceptive methods due to side effects and health concerns in the country.[2] Students from 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.

2.1. Quirino Province

Quirino Province lies in the southeastern portion of Cagayan Valley (region II). 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 as 74 percent Ilocano, 14 percent Ifugao, and the rest Igurats, Calingas, Bucalots, and Tagalog. 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 captial town while Diffun, being contiguous to Santiago City in Isabela, is the commercial center.

The dominant ethnic group in the area are Ilocano who speak a language related to Malay. There is also a significant population of Ifugao, a minority tribal group found in higher concentration 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, Tagolog, Ifugao, and Igurat.

[2] The discontinuation rates due to side effects and health concerns are 5% higher in region II than in any other Philippine region (DHS: 1998).



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 clinic upkeep. Traditional midwives called hilots living in the area also perform family planning activities such as delivering babies and treating women for infertility.

2.2. 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. Difune, the commercial center, was included because it represented the most urban population in Quirino province. Cabaruguis, 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 Cabarouguis.

Each municipality in Quirino Province has a central municipal health unit that serves a number of barangay health stations (barangay being the smallest governmental unit) staffed by midwives and health workers. Four health clinics were chosen as the clinical study sites: Saguday rural health station, the Diffune municipal health station, and two health stations in Cabarouguis--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 Cabarouguis (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, Difune, 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 and/or traditional methods such as calendar/rhythm method/periodic abstinence, mucus/Billings/ovulation, basal body temperature, symptothermal, lactational amenorrhea method or LAM, breastfeeding, and withdrawal unless they are specifically asked to do so by clients.

Table 1. Municipality, Health Stations, and Study Clinics

Municipality	*No. of Health Clinics*	*Study Clinics*
Cabarroguis	*1 Municipal Health Station* *5 Barangay Health Station*	*Municipal Health Station* *Debibi Rural Health Station*
Diffune	*1 Municipal Health Station* *4 Barangay Health Station*	*Municipal Health Station*
Saguday	*1 Municipal Health Station* *3 Barangay Health Station*	*Rural Health Station*

2.3. Study 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 that 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 staff person. The team was presented with the project plan and purpose, and 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 5-day training and fieldwork practice.

2.4. Study Overview

Several field methods were used to gather the study data from married women, couples and providers who serve them during two phases of fieldwork. The central method was to conduct semi-structured 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 permission of the women. Twenty-four of these women were interviewed again, in-depth, along with their husbands. 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 midives and clients and BHWs and clients were taped recorded and a rapid assessment of the study clinics was also conducted. Pharmacies in the local area were visited to assess 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.

2.5. 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.

2.5.1. Phase I

During *Phase I*, semi-structured interviews were conducted with *81 female* current and past users of contraception, 20 from each of the four study areas: Saguday, Diffune, 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.

2.5.2. Participant Recruitment and Sample of Married Women

A 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. 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 followup 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., pill, IUD, injection, and condom. Every third women 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 four 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 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. Sample of Women

	Current Users New Acceptors / Ongoing users		**Past Users**	**Total**
Cabarroguis (Debibi)	5 5	5 5	10 10	40
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, Tagolog, Ibaloi, or Pampaguena, 3 Igorot, 3 Tagolog, 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 rather than metropolis such as Manila. The married women ranged from 18-46 years of age. For details on age, number of children and ideal number of children of participating women please see appendix 1.

2.5.3. 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, 2 condom resupply visits; 1 IUD removal. New client visits (either switchers or new to any method) were also recorded including 7 OCP, 1 IUD insertion. One woman came in for infertility problems as well. The remaining were BHW visits for resupply.

2.5.4. 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 sub-sample of couples was chosen. The sub-sample 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.

2.5.5. Phase II

During *phase II*, follow-up interviews were conducted with *25 couples* drawn from the sample of 80 women.[3] Building on the contraceptive histories obtained during phase one, the open-ended interviews during phase II explored themes that emerged from that data in further depth and the couple's experience prior to contraceptive decision-making 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

	Couples	*Providers**
Cabarroguis	*7*	*6*
Diffune	*8*	*7*
Saguday	*8*	*7*
Total	24	20

**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.

A round table session with providers, study team members, administrators, and community members was conducted after completion of the preliminary report. Over 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 quality of care, mainly counseling issue that emerged from the feildwork 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.

[3] Several of those identified for re-interview refused to be re-interviewed 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.

Chapter 3

Menstruation and Fertility

In order to understand modern contraceptive practice from an ethnographic perspective one must have some understanding of the domains of daily life that are affected by the use of the pharmaceutical contraceptive methods. All of the major pharmaceutical methods used in government clinics in the Philippines, except condoms can and do influence menstruation and of course, fertility. The major non-pregnancy related reasons women give for discontinuing a modern method of contraception are health concerns and side effects. Thus, women's practices and understandings of menstruation and, to a lesser extent, fertility are contextualized and explained in terms of how they relate to health and illness in this chapter. The understandings and practices of Ilocano, Ifugao and women from other ethnic groups who participated in the study did not vary significantly, thus their responses are analyzed as a whole below. The menstrual practices of women we interviewed in Quirino Province bear a striking resemblance to the practices of Malay women as described and interpreted by Laderman in the early 1980s (Laderman: 1983). They are also very similar to those among women in a southern Tagolog community described by Jocano (1973) and more recently, those of women living in Manila described by Michael Tan (1999). These practices are for the most part derived from humoral theory as practiced in peninsular Southeast Asia. Although these practices may be more abbreviated in some areas of Quirino Province, the assumptions about the body, menstruation, and fertility underlying these practices influence couples' interpretations of the effects of modern contraceptive method use and thus their decisions to continue or discontinue a method.

3.0. Exposure to Cold

When we asked women how they care for themselves during menstruation[4] most women said that to varying degrees, they avoided eating sour fruits and vegetables and other "cold" foods during their menstrual period. For example, Josie[5] from Debibi said the following (translated by Mary):

> *"I'm avoiding sour and cold foods because when I eat sour fruits my menstruation stops and it causes me headaches. Then my menstruation is not continuous."*

Like Josie, those who avoided sour and cold foods during menstruation said they did so because eating them caused the menstrual blood to stop flowing.

Laderman summarizes the humoral concepts of hot and cold as follows:

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[4] Menstruation is commonly referred to as "regla," a borrowed term. "Agsangaili' is the Ilocano term for menstruation and is also used sometimes.

[5] Pseudonames are used for all study participants and interivewers.

"The Malays, in common with people from many past and present cultures, categorize foods, diseases, and treatments according to intrinsic qualities, which they refer to as 'heating' or 'cooling.' Although temperature may be one consideration (e.g., using a fire to heat the beds of women in the puerperium), they are not equivalent to thermal measurements. In the Malay system, humoral qualities of foods are not changed by altering their temperature. Thus, squash boiling on the stove is still humorally 'very cold,' while alcohol, even if iced, is still 'extremely hot.' Since illness is thought to occur when the equilibrium of these opposing elements is disturbed, the practical application of this theory aims at restoration of the body's balance, using foods and treatments that decrease the element in excess and/or increase the deficient humor."

The aim of humoral prevention and treatment, in other words, is to restore the body's balance. It follows that by avoiding humorally cold foods, such as sour fruits and cold drinks, these women are preventing further increase of the cold element during menstruation.

In addition to avoiding cold food, women also said they avoided taking a shower, either on a certain day or time of day during menstruation, and/or avoided washing certain parts of the body.[6] For example, Jovie from Saguday said,

"*I don't take a bath during the first day of my menstruation."*

Like eating cold foods, bathing is considered a cold inducing activity and was said to cause menstruation to cease.

Laderman's interpretation of the natural dynamics of blood in relation to illness among Malaysian women may explain the theoretical underpinning of these women's observations that eating sour and cold foods and bathing can slow menstrual flow.

"Malays consider blood so hot that it cannot clot within the body, though it can when it comes into contact with cold air. Changes in body temperature, however, can affect the speed of blood flow. A hot illness produces a rapid pulse and a cold condition a slow pulse, since cold thickens the blood."

Thicker menstrual blood moving closer to a body orifice, it follows, will not flow as easily. Thus, one would not want to expose oneself to cold in the form of food, bath water, or weather because it could further inhibit the flow of blood. In daily practice, the sign that may indicate overexposure to cold during menstruation is a sluggish or absent menstrual flow that produces headache and dizziness. Avoiding cold, however, does not fully explain other aspects of Quirino women's daily practice during menstruation.

[6] Some parts of the body are considered hotter than others and some times of the day are likewise considered hotter than others. See Laderman for a detailed explanation.

3.1. Dropped Uterus

Another common response to the question of how a woman cares for herself during menstruation was that heavy work, such as lifting and carrying heavy things or scrubbing the floor, were put off during menstruation. For example, Josie continued her discussion of how she takes care of herself during menstruation by observing,

> *"I don't do heavy chores like washing of clothes [when I am menstruating] because I will feel pain and cramps all over my body."*

Another woman from Saguday observed that both

> *"Eating sour foods and carrying heavy things . . . can stop the flow of your menstruation."*

Although women said it was often not possible to avoid heavy labor due to the demands of daily life, they tried to do so in the ways that *were* possible in order to avoid cramps and inhibited menstrual flow, such as putting off scrubbing the floor or doing laundry.

In addition to experiencing abdominal pain, women said that if they did heavy work while menstruating, it could cause their uterus to "drop" down, i.e., literally drop downward in the abdominal cavity. Orlando from Difune explained how this was possible:

> *"Our uterus at that time is slippery, so there's a tendency that it will slide down."*

Laderman's observations about the body humors may provide some insight into the meaning of her observation about the slippery quality of the uterus during menstruation.

> *"The organizing principle of phlegm or lendir, the cold body humor, is that of sliminess: the mucus of a runny nose, lymph, semen, egg whites, the viscous matter in okra, certain bananas and other slimy fruits and vegetables, and the slime on the skin of certain fish."*

In other words, "our uterus at that time is slippery" suggests that the uterus itself is cold during menstruation, a condition where one expects a slowed blood circulation within the organ. Regarding displacement of body parts within the body Laderman observed that

> "*…When blood does not flow normally through an area, it [the area] becomes cold, and muscles move from their true places."*

Thus, when one strains to lift heavy things the slippery, cold uterus may literally move down lower or be displaced in the abdominal cavity by the tensing of the abdominal muscles.

When asked "could the uterus actually slide out of the body?" another respondent from Saguday said,

"[It might] not actually come out, but I think the uterus will slide down because it's slippery. Yes, [I've experienced dropped uterus] …that's why I used to let my uterus be lifted up whenever I felt pain in my menstruation. . . usually the hilot will massage my uterus to bring it back to its normal position. Then after that, I don't experience painful menstruation anymore."

Other women also said that uterus slippage was indicated at times by the feeling of cramping during the menstrual period. Jocano also attributed the phenomenon of "cramping" also commonly experienced as "chest pain" in the southern Luzon Tagolog community to an imbalance of hot and cold:

"Chest pains are due to puntada, a form of muscular cramps caused by the imbalance of hot and cold elements inside the body. It can appear in any part of the body, although the chest is most vulnerable to puntada attack."

Many women said that heavy cramping during menstruation (which could be said to result from an imbalance of hot and cold) could result in a dropped uterus. This type of displacement of the uterus from its upright, high position in the abdomen was said by some women (as well as hilots), to potentially cause infertility.

3.2. Eating Bitter (Menstrual Regulation)

Although eating sour foods can inhibit the flow of menstrual blood, the hilots we interviewed explained that eating certain potent bitter roots, which are used for medicinal purposes (and not consumed as food) and considered to be "hot" induces menstruation. Thus it can be used to regulate menstruation especially for women with severe dysmenorrhea. Patricia, a hilot, explains,

"Especially those with abnormal menstruation or who suffer from painful menstruation, I just tell them to drink something bitter . . . especially makabuhay; yes, it is considered an abortive herbal . . . Cut it into small pieces and when the patient can endure the bitterness, then she'll boil it and drink the soup . . . The makabuhay is the one I let them take when their menstruation is delayed because, if it is already one month, then I don't give them anything anymore because they might commit abortion."

She goes on to explain that,

"The bitter taste brings on menstruation."

The bitter taste in other words, is at least in part what makes the root efficacious.[7][8]

[7] Jocano catalogued more than 20 formulas for menstrual regulation in Tagolog pharmacopia in the 1970s.

[8] Other medicines that were mentioned in our discussions that bring on menstruation were mahogany, bitter cucumber, Kalachuchi roots, bitter grass, and makahiya.

All four of the hilots we interviewed were concerned not to cause their client to have an abortion. If the menstrual period was delayed more than a month, they said they would not provide the medicine. Women also said they generally go to the hilot for correction of the placement of the uterus rather than for menstrual regulation, as Josie pointed out,

"[I go to the hilot] only when I feel abdominal pain. Not when my menstruation is delayed."

Eating sour fruits and vegetables or doing heavy work may cause the menstrual flow to stop, and eating potent bitter substances brings it on. However these practices should not be construed as hard-and-fast rules derived from a standardized view of how the body, (either the biological or humoral) functions.

3. 3. Individual Variation

Humoral systems are dynamic rather than taxonomic and an individual woman's practices during menstruation are derived from personal trial-and-error experiences rather than simply from an abstract knowledge of the social rules such as "do not eat sour or cold foods when you menstruate." For example, Jane from Zamora recalled why she started avoiding sour fruits during menstruation.

> *"They said, you should not eat sour foods, and so when I had my menstruation, I tried going against what they told me and I had a stomachache; my menstruation stopped, and from that time on, I did not do it anymore."*

Although the majority of the women interviewed said they took some degree of precaution regarding exposure to cold during menstruation, there were variations in women's practices, influenced at times by subtle bodily sensations such as cravings or feelings of warmth. Although many women said they felt a craving for sour foods before or during their period, others said they had no such cravings. Since they did not want to eat sour foods, no special effort was made to avoid them. Others said that they took a bath because they felt warm. One woman even had the exact opposite response as the majority of participants to eating sour foods. Loretta from Saguday said the following (translated by Jo).

> *"When I was still single, I usually avoided eating sour fruits. I had an experience before. I ate sour fruits, and blood continuously flowed for three days, and I was even hospitalized because of this profuse bleeding that I experienced."*

That eating foods can affect one's menstruation is generally not in question among these women. The question is how a particular person reacts to these foods and under what conditions. These bodily responses are key for understanding how "the rules," such as not eating sour foods during menstruation, should be followed by a particular individual.

A few of the women said they did not avoid sour and cold foods or bathing (even though they knew others did) because they did not "believe" in those things. For example, Mary who lives in Saguday said the following (translated by Maria):

"I don't believe that when you eat sour food and take a bath during menstruation, your blood will stop and you will become crazy."

Although some women we interviewed distanced themselves from these practices, their experiences with the side effects of modern contraceptive methods indicated that they too held similar common-sense views of the body. One might wonder at this point why women are so vigilant about menstruation. To understand this issue more fully, one must look at the "nature" of the female body.

3.4. Dirty and Clean

When we asked women why they menstruate each month, a variety of explanations were offered, for example, it is a "sign of womanhood," a sign that one was "not pregnant," or "God's will." It was interesting that although women's speculations on the ultimate reasons for menstruation varied, their proximal, functional reason did not. All the women interviewed said that menstrual blood was dirty and needed to come out for a woman to be clean.

For example, Gloria from Debibi said,

"It is natural for a woman to bleed so that we will be clean."

Although her statement emphasizes the dirty nature of women, most women used the concepts of "dirty" and "clean" to convey a functional purpose to monthly menstruation, one that relates to the cleaning properties of blood. For example, Carmen from Debibi explained

"That [menstruation] is normal for women . . . to cleanse the dirt in our body."

When the interviewer asked,

What do you mean by dirt?

Carmen answered,

"I mean the dirt in the blood will come out."

Another woman put it like this:

"It [menstruation] comes from the inner part of the body; the dirty blood is accumulated, and then it comes out."

In other words, menstrual blood literally cleans and carries the dirt out of the body.

When asked “what might happen if your period stopped?’ women responded most often with their own symptomatic experiences of sluggish or absent menstrual flow. For example, Marissa from Debibi noted that

“If the blood does not come out, I am more irritable and hot tempered.”

Elma from Difune said,

“If your menstruation would stop it could cause dizziness.”

Mary from Difune responded with a more theoretical explanation, saying

“The blood might clot inside the uterus and it [menstruation] will cease later on.”

then added her experiential reasoning*,*

“Besides, if the blood will not come out, it will cause a headache.”

Rose, a Barangay health worker from Difun, relates the phenomenon to overall blood circulation (translated by Aurora):

> *“I think this [menstruation] is already normal in a woman’s life. Besides, it may clean the body of a woman because the dirty blood comes out every month, so there is a normal circulation of the blood.”*

In other words, this provider is saying that women need to menstruate to have normal blood circulation.

Some women speculated about the potential long-term consequences of not menstruating. For example, Mila from Difune said (translated by Jo),

> *“They say that if the blood doesn’t come out, it will be formed as tumor or cyst.”*

Other responses included, “you will be poisoned,” “you could become insane,” or “crazy.”

3.6. Fertile Time and Sex

When we asked women when during the month a woman was most fertile, most women said that they were fertile when the uterus was “open.” Emily from Debibi explained this phenomenon saying,

> *“During our menstruation it [the uterus] opens and it closes after menstruation…during the days that the uterus opens and you have sexual contact then you will get pregnant, that is according to their [friend’s] experience.”*

Although women generally understood that the uterus had to be open both to menstruate and to get pregnant, they were not sure about the exact timing of

the opening and closing of the uterus. In addition, some couples said that they did not have sex when the wife was menstruating because it was unsanitary. For example, while discussing the extended menstruation caused by the pill this husband said,

> *"There was a time that she had her menstruation continuously for three months. So we couldn't have sex because it's very unsanitary to have sex during her period."*

The days immediately following menstruation were also considered the fertile time.

> *"I think the uterus is open seven days after the menstruation and it is closed seven days before the menstruation. I am not sure of it. That's why I'm not using the natural method."*

The responses of women who seemed more sure of the timing of this opening-closing phenomenon varied; one said the uterus was open from the third to the fifteenth day after menstruation, and another said it would be open for a maximum of nine days after menstruation and then it closed. The non-fertile time according to the women who were able to give detailed answers to this question fell within the biomedically defined "fertile time."

Fertility was not only related to the openness of the uterus but also to the position of the uterus in the belly. For example, Joyce, a hilot explained it as follows:

> *"Our uteruses are different from one another. There are those whose uterus is turned in the opposite direction, that causes painful intercourse. . . I had to flip it the other way, so the opening would go in the right direction, which should be straight. . . There are those whose opening is tilted on one side. I had a patient before, and she'd been married for twelve years and couldn't get pregnant. I learned later her uterus was slightly tilted on the left. After I fixed it, she was able to conceive. She now has three children."*

In interviews with hilots we found that "turning the uterus" was a method of contraception provided by them to women living in the study area, but no women mentioned that they actually used a hilot for contraception. When we asked whether they might prescribe something to bring on the menstruation of a woman who was taking contraception the hilot answered,

> "*If a doctor prescribed that to them, they should go see him if they feel something is wrong."*

Conversely, women who were having infertility problems might go to the hilot who could also massage a displaced uterus back into its proper position and increase their chances of becoming pregnant. The hilots provided infertility treatment for women that primarily involved massaging the uterus upright to a high position in the abdominal cavity. Valarie, a hilot from Difune, explains,

“I help those who are about to give birth and those wanting to have children but cannot conceive. They will come to me for advise. I would check whether her uterus is in place. If it is down, then I have to massage it to get the right placement. They would complain of painful menstruation, and I suspect their uterus is not in its proper place. They would ask what they should do, and I tell them to massage it, and if the good lord permits it, they will have children. They will ask me to do it myself since I am known in the area to handle such cases.”

Clearly, menstruation is part of what makes and keeps women living in Quirino province healthy. Most likely this holds true for women living elsewhere in the Philippines as well. Theoretically speaking, menstruation is important for good circulation of the blood and keeping the bodily humors in balance. Although most women would not refer to the humoral theory that underlies their embodied common sense, they incorporate practices into daily life that will ensure a consistent menstrual flow, such as avoiding exposure to cold foods and bath water, and heavy work during their menstruation. Sexual practices are modified by the occurrence of menstruation for some of the couples due to the “unsanitary” nature of menstrual blood. The fertile period occurs when the uterus is open i.e., during menstruation and for a variable period of time after menstruation. Hilots treat women mainly far problems related too infertility (rather than contraception) though they may also prescribe herbal medicines to bring on menstruation. The next chapter explores the experiences and speculation of women and couples about the use of contraceptive methods.

Chapter 4

Hiyang or Not?
Bodily Effects and Speculation Related to Contraceptive Methods

This chapter examines participants' bodily experiences of using temporary pharmaceutical contraceptive methods and their speculations on the effects of the various methods. Husbands of the women also participated in speculation on the effects of the methods and the decisions to discontinue or continue a method and their comments are interspersed throughout the chapter as well. The temporary contraceptive methods promoted through the government-run family planning clinics in Quirino Province included one oral combined contraceptive pill (Lo-gentrol), Depo Provera (DMPA), the Copper-T intrauterine device, and condoms. The chapter will focus on these methods, although other methods are also used in Quirino Province. Of the 81 women we interviewed for this study in the three districts, 56 had used pills, 44 had used DMPA, 29 had had an IUD, and 11 used condoms with their husband at some point in their reproductive career. Some of these had used the methods more than once and/or used multiple methods over time.

4.1. Hiyang or Not? Effectiveness versus Suitability

When we asked participants "was X contraceptive method effective?" women tended to respond with a general assessment that contrasted the negative effects with those considered positive. For example, in a direct question about whether the pill is effective, Joy from Saguday responded,

> *"No, [the pills were not effective] because of the side effects. . . . I had headache, dizziness and I'm hot tempered. . . but in a way yes, because I never got pregnant."*

Most of the time either the wife or the husband summarized their responses to the question of efficacy or side effects with a judgement of whether or not the method was "*hiyang*" for the woman. When a couple from Saguday was asked for example, why Aurora had stopped using the pills, she said,

> *"My skin dried up and I grew thinner. I'm even hot headed during the time I use the pills."*

Joe, her husband added clarification saying:

> *"She's not hiyang with it."*

According to the Tagalog-English dictionary *hiyang* means

> *"good, agreeable: suitable; compatible" (Panganiban 1982).*

Hardon explains the use of this concept in the Philippines as follows:

"It is traditionally used in relation to food, company, and medicines. If a drug has no effect, then people tend to conclude that the drug is 'not hiyang' (not suitable) for the patient." (Hardon; 1992). [9]

Indonesians, Malaysians and Hmong all use similar concepts (Hardon 1992: Henry: 1997).

The "hiyang-ness," or suitability of a particular method to a person is not based on a shared understanding of a standardized humoral or biological female body or a fixed body of any other kind. Rather the assessment is related to a fluid set of circumstances and bodily responses that can change over time.

Paula from Debibi used DMPA for a year and a half. When telling her story, she first told us that the method was *hiyang* for her*:*

"None [had no side effects]. I think it is hiyang for me because I did not feel uncomfortable unlike other people who had so many stories to tell regarding its side effects."

Later in the interview, Paula told us that after a year and a half of use, she was not *hiyang* to the method because she had become amenorrheic.

Several women used the western concepts of resistance and immunity to translate the concept of *hiyang* to interviewers. Mary, for example, explained why she was more resistant than others to the methods:

"According to other mothers, they felt dizziness, headache and had high blood pressure. I only felt those for the first month of using pills. After the first month, there was no more pain. So it was hiyang for me. Another mother said it was not hiyang for her because she has low body resistance towards side effects.
For those who have high blood pressure, taking pills will aggravate their sickness. But for me I have high body resistance regarding side effects."

Mary is more naturally resistant to the methods' side effects than are others including people with chronic conditions. She, being more resistant, was able to adapt to the pill after a month where as other women could not. She used the concept of immune to explain how the body's response to the hormonal methods can change over time, saying

"Also, your body becomes immune with pills if you use it for a long time. Thus, you won't feel the side effects. If you stop using pills, give birth, and take the pills again, then it will be alright for you."

Immunity was also used by Betty (and others) to explain not only how a person could be *hiyang* at one point and not *hiyang* at another to the same method, but also why women who liked a particular method stopped using it periodically or alternated it with another method. When asked,

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[9] Although the terms are not equivalent, for the purposes of this paper "suitability" will be used as an English substitute for "*hiyang*."

"Do you plan to go back to the pills?"

She responded,

"Yes, but I want to rest first in taking the medicine because I might get immune to it."

Although an appraisal of *hiyang* was a complex matter involving a general sense of wellbeing, including the absence of unpleasant bodily sensations and the presence of normal body functions, some general observations can be made about what effects will result in a *hiyang* assessment in relation to the contraceptive methods in particular.

4.2. Growing Stout or Thin

A major reason cited by couples for why a method was or was not *hiyang* was whether a woman grew stout or thin while using the method. [10] For example, Ann from Zamora said,

"I heard that if you're going to use pills, you will become fat if you were hiyang with the method, but if its not, then you will become thin."

Other women speculated along similar lines about the use of depo, for example, Mercy from Saguday said,

"Yes, and it [depo] was good for them because they were having their menstruation and they grew stouter."

Weight gain in other words, is a common-sense bodily sign of the suitability of a contraceptive method to a woman. Among the study participants 15 of the 44 who had used DMPA and 10 of the 56 who had used pills said their weight changed with method use; most had gained.

This common sense regarding weight change seems to be shared on some level by at least some of the midwives we interviewed, indicated by speculations about method effects. For example, observing that some women gain and others lose weight while on the hormonal methods, one midwife speculated about whether weight gain or loss might be attributed to the IUD as well.

"For those who have depo, I notice many of them gain weight, but there are also some who have depo and they get thin. There are also some who have pills who became fat and some thin. It's the same way with the IUD. I had one patient who had an IUD and she was thin for two years, but after two years, she became very stout. I don't know if it's related to the IUD. . . the patients attribute the weight gain to pills but not to the IUD."

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[10] In the report from the 1980s study of a low income Metro Manila neighborhood from which the above quote is drawn, Anita Hardon writes that family planning methods in general were considered "not hiyang," in other words, not suitable for use by the entire group (Hardon: 1992). It is interesting to note that in the current study (conducted in a different location and years later), "hiyang" was used to describe the suitability of a family planning method to a particular individual rather than the unsuitability of family planning to the group as a whole. This suggests a relative change in the acceptability of family planning over this period.

Observations about growing stout or thin were also mentioned in relation to using the withdrawal and condom methods as a way of assessing the suitability of the method to the person.

A significant number of participants said they chose a particular method precisely because they wanted to gain weight. For example, when asked why she chose DMPA, Rose from Zamora said;

> *"I first had pills, but when I saw a relative who used depo and became stout, I envied her, so I said, I'd also like to try depo so that I will gain weight also."*

Women sometimes voiced an expectation that the method should promote weight gain and thus good health. For example, when Edith from Saguday was asked what the side effects of the IUD were, she said,

> *"I felt dizziness, and I didn't grow stouter."*

Although weight gain generally was considered a sign that a method was likely *hiyang*, it did not mean that the weight gain was always desirable. Florida from Difune said,

> *"My problem [with the pill] is that I'm gaining weight and I'm afraid I might even grow bigger"*

When asked whether she planned to use another method she responded,

> *No, because in my use of pills I got back my mensturation and I'm having it every month. So I don't think I would like to try another method."*

Although it did not change their assessment of suitability, at least four women we interviewed felt they had gained too much weight while on their hormonal method and wanted to loose some of it.

Though weight was very important consideration, the most common reason given by women for the unsuitability of a hormonal method (or for a hormonal method not being *hiyang*) was the effect the method had on menstruation.

4.20. Hormonal Methods, Side Effects and Interpretations

Among our study participants, 18 of 56 pill users and 34 of 44 DMPA users said they experienced significant changes in menstruation; most a decrease in the amount of menstruation. These changes in menstruation were said to result in the accumulation of blood that in turn caused the other common side effects reported by women using hormonal methods, such as dizziness, headache, hot headedness and high or low blood pressure (see table 4 and 5). Women's experiences in this regard followed the social constructions of high and low blood.

Table 4. Side effects reported by pill users in Quirino Province

Headach e	Dizzines s	Menstrual Change	Hot headed	Blood pressure change
25	19	18	16	8

N=56

Table 5. Side effects reported by DPMA users in Quirino Province

Menstrual Change	Amenorrhe a	Headach e	Dizz y	Hot headed	Blood pressure change
34	24	22	17	11	5

N=44

4.21. High Blood

Several women we interviewed found a connection between experiences of "high blood" and the effects of hormonal contraceptives, specifically the decrease or loss of menstruation. In a conversation about why she stopped taking DMPA, which she said was her favorite method, Eve commented as follows:

> *"It's the lack of period. That's the main reason. Because there's a rumor that when you don't have your period, the blood accumulates and goes to your head and it can make you go crazy. Though I don't actually believe it. I'm just intimidated by it."*

The retention or accumulation of dirty menstrual blood in the body and the symptoms women attribute to the methods seem consistent with the high blood illness as described by Laderman:

> *"Some people develop abnormally hot blood, either because of an illness that causes the blood to become dirty (for instance sembap, characterized by edema) or because of drah tinggi (literally, high blood). Since overheated blood is thought to rush to the head, considered normally hotter than the rest of the body, causing dimmed vision, headache, dizziness, and faintness."*

The symptoms of high blood were said by Quirino residents to include anger, headache, dizziness, blurry vision, pain in the nape of the neck, and fainting. If left unchecked high blood could lead to passing out and bleeding from the nose and mouth.

Most participants thought of the illnesses "high blood" and "high blood pressure" and their consequences as basically the same. For example, Mary used the two terms almost interchangeably when describing the causes of high blood.

> *"Maybe because of the food they eat, like salty and fatty food. And also because of the weather or our climate. If it is hot, many are suffering from high blood because their blood pressure tends to rise."*

When asked the cause of high blood women responded that being hot tempered, being angry, the hot climate, eating fatty and salty food, getting no exercise, being over worked, inheritance and emotions can cause high blood. It is interesting to note that salty and fatty foods are both considered hot in the humoral system according to Laderman, and thus, there is a strong convergence between the causes (or prevention) of hypertension and high blood.

The issue of whether the hormonal method actually causes high blood was a matter of dispute and speculation. For example, when Eve was asked whether her experience of high blood while on DMPA was due to the injectable contraceptive, she said,

> *"I think so. But I guess my high blood was probably due to the lack of period. Though in a lot of instances it [lack of period] doesn't imply that. Also, perhaps because of my diet. But sometimes I believe that it's because of depo because I don't menstruate so I'm wondering where those blood are going."*

Other women said that taking the pill also caused headaches and perhaps high blood. For example when we asked Rose from Zamora why she stopped using the pill she explained it like this:

> *"I was having a headache and feeling dizzy. I was having high blood pressure. . . My menstruation—I usually had my menstruation for about seven days, and then when I was using pills, I just had it for two days. I even considered it as the cause of my headache. . . Others [also] say their menstruation is very little [with pill use], and they suffer from headache."*

Rose's family planning clinical record showed she had an average blood pressure reading of 110/70 for 9 months. A reading of 140/100 was also recorded, and that was when she was advised by the midwife to stop the method. Although she did not say directly that the pills caused her hypertension, she did say that she was "more *hiyang* with the IUD" because "she felt better" and did not experience high blood pressure.

Mercy from Debibi reasoned that pills caused her high blood pressure because

> *"[before I started pills] they check the beating of my heart, and my blood pressure. Since I have a normal heart beat and blood pressure, so they gave me pills."*

She, like Rose from Zamora said that other women had had the same experience:

> *"Yes, my friends and neighbors, they feel the same with what I feel only they don't like to withdraw from it [pills] just so they don't get pregnant. They also feel that their blood pressure is getting higher when they used pills."*

Low blood was also raised in the context of discussions about hormonal and IUD methods.

4.22. Low Blood

Although the risk of anemia, or “low blood” as it is often called, is routinely discussed with patients using the IUD, more speculation about the incidence of low blood occurred in relation to using the hormonal methods than the IUD. When Rose was asked whether she became dizzy after menstruating for 16 days, a question perhaps inspired by biomedical common sense, she responded,

> *“No, but actually, I felt dizzy when I didn’t have my menstruation [using DMPA].”*

One woman described the experience of low blood as follows.

> *“Until now I feel cramps all over my feet. There are times when my blood pressure becomes low then I can’t move my whole body…I became anemic. It is true that I gained weight but I became anemic. Actually when I had my depo, that’s the only time I became very stout.”*

The idea that one could grow stout at the same time as having ill health in the form of low blood seemed to be a bit of a surprise or contradiction to many women.

“Vitamins” or ferrous sulfate tablets were prescribed to treat anemia and several women who had experienced excessive bleeding while using the IUD took ferrous sulfate tablets for it. Because of confusion between low blood, low blood pressure, and anemia, however, some women wondered whether the “brown pills” or the ferrous sulfate tablets in the Lo-gentrol pack could raise the blood pressure.

4.23. Accumulation and Tumors

Accumulation or excess was raised in various ways by hormonal method users, in relation to accumulated menstrual blood as was illustrated above but sometimes in relation to pill residue or the pills themselves. For example, Purie from Saguday said that some women in her neighborhood speculated that

> *“After 3 months [of using the pills], you have to have cleansing.”*

She is referring to the uterus that is in need of cleansing after one takes the pills. It is conceivable that because women menstruate less when on the pill, they are in need of cleansing every so often. Or, for some women, perhaps those unused to theorizing about the functioning of the body, the cleansing might involve ridding the body of the pills themselves that have accumulated in the uterus.

For example, during a pill resupply visit at a clinic after the midwife asked

"what are your experiences in using pills?

The following exchange took place:

C: I felt that my hypogastrium has become hard and painful.
P: Is it always like this or only when you are about to have your menstruation?
C: When I'm about to have my menstruation.
MW: That is normal; we all feel that before we have our menstruation.
C: But the pain is different. It is as if I were pregnant. It became hard here and I feel a lot of clots.
MW: What else have you felt?
C: Sometimes I become irritable and experience headache.

She goes on to explain that she started experiencing this a year after beginning the pill. The midwife then recommends that the client undergo a pap smear, and the client said,

C: Really, my problem is my hypogastrium. . . Somebody asked me if I crushed the pill before taking it but I told her that I just take the tablet, I never crush it. She told me that it was the reason why I suffered hypogastric pain.
MW: Maybe you were thinking that the pills were accumulated already?
C: Yes, ma'am.

The midwife tries a physiological explanation of the impossibility of this, and then says,

"If you want to prove that the pills will be dissolved, try to put one in water or chew it and take it with water."

At least six women taking pills told interviewers that they crushed or dissolved pills before taking them for the reason that they wanted to avoid accumulations in the body. Another five based their schedule for taking the pill on whether they were having sex with their husband. For example, Georgia from Saguday said,

"*When we don't have sexual contact, I don't take the pills. If we don't have contact for one week, then for a week, I don't take the pills"*

It is common practice for husbands and wives to separate for periods of time for work purposes. To avoid overuse of pills and perhaps to prevent things such as accumulation they stop taking the medicine when they are not in danger of geting pregnant.

4.24. Men's Speculation and Influence on Method Use

The majority of men said that it was generally the woman who decides what contraceptive method to use; however, most of the women in the study did say that they consulted their husband on the method before going to the clinic. The husband's influence on method most often occurred after his wife

was using a method through lobbying her on issues related to the side effects of method use. For example, Elsie, a BHW from Difune, and her husband Joe discussed their use of the methods as follows during a couple of interviews:

> *"I heard that a woman who used pills for a long period of time had a tumor. They removed her uterus because of the tumor and said it was because of her use of pills."*

Elsie answered,

> *"When he told me about that issue, I just ignored it because I don't think it was the cause of her tumor. There was no basis, so I just pursued my plan to use pills. I used it for six months until I decided to stop using it . . . because my husband keeps on telling me to stop because it might be dangerous."*

Later, she told us that she was also at times hot tempered on the pills.

> *"I'm always hot tempered and have headache oftentimes. I also felt like I'm conceiving; I'm dizzy and weak. But later on, I learned to adjust."*

To which her husband responded,

> *"Well, when I observed her being hot tempered, I told her about it, and she said it was because of the pills. So when I noticed that she's hot tempered, I just go out. I just ignore her. I even told her to stop using it, but she didn't like it because she might get pregnant. I just let her use it until I heard that issue about the pill-user. I kept on telling her about it until she decided to stop already. . ..Because of the issue about the pill user."*

She said,

> *"He keeps on telling me about it so I got frightened and decided to stop it already."*

Some of the effects of the methods, whether they would exist with or without using the method, are obviously shared between couples. Through dialogue about the long-term health consequences of the methods, husbands are able to influence the contraceptive practices of wives as Joe did Elsie.

Women also reported changes in menstruation with the use of the IUD however this did not generate the same amount of concern or speculation as a decrease in menstruation.

4.40. IUD

Women who used the IUD, on the whole, experienced fewer side effects and speculated far less about the method. In addition, the interviewers did not record any dramatic stories related to the IUD as they did for the use of pills. However, the nature of the uterus, rather than the qualities of the blood, appeared to be the major common-sense reason for not choosing the

IUD on the part of Quirino women. The nature of the uterus and to some extent the side effects of the IUD were cause for speculation. Menstrual changes, specifically an increase in menstrual flow were reported by 10 of 28 women who had used the IUD. Dizziness, and, abdominal pain and cramps were other side effects that occurred in 6 and 7 of the 28 women using the method respectively. The sexual side effects as mentioned earlier, were short lived for the majority of the women using the IUD. Headache, the most common reported side effect of the pill, said to be a widespread generalized complaint of women using contraception in the Philippines, was nearly absent in IUD users.

Table 6. Side effects reported by IUD users in Quirino Province

Menstrual change	Dizzy	Abdominal pain &/or cramps
10	6	7

N=28

4.41. Impractical Method for Farming Women

Because of the state of the uterus during menstruation as open, cold, and slippery, it was said to be unsuitable and impractical for farmers, who must work hard on a daily basis for survival. First, it would prevent a woman from working in the wet rice paddies. For example, Morie said,

> *"[With] the IUD, I can't stay in water for too long because I always go to our rice field before. The uterus is open and you can easily be cold on it . . . I can't carry heavy things when I was using the IUD."*

The other reason for not choosing the IUD was that for hardworking women, it might be expelled during menstruation.

> *"Yes, I went there for check up and they found out that my IUD had been lower than its normal place. . . Because even during menstruation, I carry heavy things, which were not supposed to be, but they taught me to place it back to its correct position."*

Two women reported losing their IUDs during their period and attributed it to the hard work. In Debibi hard work does not simply entail carrying heavy buckets of water but also manipulating 70 pound sacks of bananas. Not every one experienced this however.

Emma from Debibi said she experienced no such problem:

> *"None [no side effects]. Some say that you must not lift anything heavy to prevent the occurrence of side effects. For me, I still lift heavy things but until now, I did not feel any side effect. . . the side effect would be that it would come out."*

Women often had no choice about when to work or not work because the planting season was so dependent on when the rain falls. Women spoke of other reasons for not getting an IUD.

For example, Georgie reflected on the drawbacks to getting an IUD as follows.

"I heard from others that they were saying they were ashamed to have the IUD placed, and they were saying the IUD might hurt the penis of the husband. But I still tried it because I don't like to be pregnant every year."

Other women also said they were hesitant to have an IUD placed because it might hurt to have it put in or because they were ashamed.

4.42. Increased Menstrual Blood Flow

The most common side effect mentioned by women using an IUD, was an increase in menstruation. Mori from Saguday, for example, explained her experience using the method as follows:

"What I observed is that the blood that comes out from me is greater in amount. Although I'm still spending the same number of days menstruating."

These problems generally occurred during the normal menstrual period. Some said they had more cramping at those times while the IUD was in place. In some cases the IUD increased the normal signs of menstruation as well. For example Evy reported increased premenstrual signs with an IUD in place. When asked

"How do you know when your period is coming?"

She responded,

"I'm hot tempered and easy to get nervous. It is only now that I experience this since I used IUD."

Rather than inhibiting the flow of menstruation, the method was actually said by some to increase or promote blood flow. The increased blood flow was often said to occur because the uterus was held open by the IUD. For a few women, increased menstruation caused them to stop using the method. For others this was seen as a positive effect. For example, Nancy from Saguday said,

"According to some who are using the same method, the IUD keeps the uterus open. That's why there is more blood coming out from the one using it."

A BHW added that IUD also promoted circulation of blood to the uterus,

"The IUD is inside the uterus, so it opens the uterus well. And it also helps in the circulation of the blood inside the uterus."

It would seem that having larger menstrual flow, in the long run, is more acceptable to Quirino women than having no menstruation at all.

4.50. Sexuality, Condoms and Other Shared Effects of the Contraceptive Methods

In conversations with both the wife and husband, the most frequently discussed side effects of the methods were the lack of menstruation, sexual dysfunction, and hot-headedness. Men also showed quite a bit of concern when their wife did not have menstruation over a period of time and might recommend that the wife stop a method. However they were not often willing prevent the discomfort and health effects of less than perfect methods with their wives by using condoms.

Out of the 80 women participating in the study, 11 said their husband had used a condom at least once. Only one of these 11 said he used condoms as an ongoing method of contraception. Various side effects were mentioned, and most were related to the degree of satisfaction the couple, usually the man, felt with use. They described it as "not feeling at ease" or "relaxed," "not excited" or "unable to reach orgasm" when using condoms. There were also a number who said they became irritable using withdrawal. One woman said she was uncomfortable with the method for fear the condom might have a hole. Another said she had pain with intercourse when her husband used a condom. Couples did not comment on condoms much more than to say they did not want to use them on an ongoing basis as a contraceptive method. Condoms were not the only methods to cause problems in couples' sexual life.

4.51. Sexual Changes

With some probing, slightly more than half of the couples were willing to discuss issues of sexuality as they related to using contraceptive methods. Many women, however were hesitant to discuss sexual issues and thus the numbers could be underreported. As many as 14 of 44 women who had used DMPA said that they experienced ongoing changes in their sexuality as a result of using the method, including lack of interest or urge, decreased aggressiveness and vaginal dryness during sexual intercourse which was reported by 8 of the women. For example, Louise from Debibi described her experience on DMPA as follows:

> *"I was dry during sexual contact. I had no desire to have sex . . . I experienced it the first time I was injected but I tried to ignore it . . . but then after some time, this dryness did not stop, and after discontinuing with DMPA, I did not feel this anymore. . . that's why I concluded that this dryness is caused by depo."*

Another woman, Aurora, explained why she felt less aggressive sexually.

> *"Well, for me, when I used pills I felt that I was less aggressive in sex because the pills control the egg cells and the sperm cell. . . maybe because both the egg and sperm cells of man and woman will be controlled. It will kill the living cells so that the egg cell will not be fertilized and thus prevents pregnancy."*

Rather than describing the decrease in sexual interest and capacity as a side effect some women through their explanations of the effects of the method on the egg and sperm cells, seemed to be saying that the *intended* effects of the methods caused them to lose sexual interest.

Regarding the sexual side effects of DMPA, Hatcher quotes the findings from a clinical trial conducted among American women.

> *"In one of the largest studies of Depo-Provera users, 17% of the 3,875 women complained of headaches, 11% nervousness, 5% of decreased libido, 3% of breast discomfort, and 2% of depression."*

It is interesting to note that while this study is not a prospective clinical trials study, it found sexual side effects from DMPA to be much more common among Filipinas. Fourteen of 44 women who used DMPA, upon reflection said they had experienced changes in their sexuality with DMPA and these are likely underreported due to women's hesitancy to speak about this type of side effect. And eight or eighteen percent specifically described an objective sign, vaginal dryness during intercourse, as a side effect of the method. This is much larger percentage than found in the American study.

The changes in sexuality affected both the wife and the husband in various ways.

Nori, for example, reported the following with DMPA use:

> *N: I had no more sexual urges. . . he noticed the change in me like I had no more sexual urges. He feels that I don't enjoy our contacts.*
> *I: Did he get angry?*
> *N: No, he feels depressed.*

Changes in sexual interest can be interpreted as a lack of love rather than a hormonal change and can cause additional marital problems. Other manifestations of the medication caused sexual problems.

For women who had an ongoing menstruation on DMPA, husbands did not like the effects because it hampered their sexual relationship. Abraham from Saguday discussed this problem as follows:

> *"Yes, she told me about it. I told her it's not good that there were times she had her menstruation and then it will stop again. I was also afraid because a woman should have her menstruation every month and there was a time that she was having her period continuously for three months so I told her to stop using DMPA because it wasn't good anymore."*

When the interviewer asked, "did that affect your sexual relationship?" She said,

> *"A lot because she was always hot tempered, and there was a time that she had her menstruation continuously for three months. So we couldn't have sex because it's very unsanitary to have sex during her period."*

His wife said

> *"I accepted it [DMPA] though I had my menstruation continuously. . . the only problem with it is I continuously menstruate which my husband complains about. But for me, it is OK as long as it protects me [from pregnancy]. When it comes to breastfeeding, it is also OK because I can still breastfeed my child, unlike with pills. Depo is convenient for me but not for my husband."*

Jane was willing to accept the side effects of the medications; however, her husband was not happy about them. Although no participant actually said they stopped because of sexual side effects, these effects likely played a role in the kinds of speculations made about the long-term effects of the methods discussed between husband and wife. For example, lobbying of the wife by the husband to stop or switch to another method. Some women using the IUD also reported sexual changes with use of the method.

About 5 of the women using the IUD experienced sexual changes; however, all but one woman who experienced these changes said that the sexual effects lasted less than a month. During the first month after use, some women said they felt pain and some men said they felt the IUD or string during intercourse. This had a short-term effect on their sexual relations.

For example, in a discussion about the IUD, he said,

> *"It [sexual relationship] was affected because she felt pain during sexual contact so I'm not enjoying it."*

One woman did report ongoing abdominal pain that made life and sex unpleasant.

> *"I experienced the negative effects after one year of using it [IUD]. I felt hypogastric pain for one month. The pain became severe during sexual intercourse and when I go to our rice field."*

This problem was attributed to the fact that the IUD caused exposure of the uterus to cold, causing abdominal pain. She eventually had the IUD removed.

An appraisal of *hiyang* in relation to contraceptive methods is a complex matter involving a general sense of well-being, including the absence of unpleasant bodily sensations, the presence of normal body functions, and sometimes even improved health evidenced by an increased appetite and/or weight gain. The concept of *hiyang* is not derived from an understanding of the body as a fixed thing, such as the biological body used in biomedical science, but rather a dynamic body that changes over time. Thus, a woman may find she is *hiyang* to a method the first time she uses it, but not the second. The western terms resistance and immunity were used to translate the concept of *hiyang* in western biomedical terms for and by the study interviewers. In relation to contraception in general, the physical signs most likely to result in *hiyang,* were continuation of normal menstruation; weight gain; and absence of symptoms of high blood such as headache, dizziness or hot-headedness. Women who used the IUD, on the whole, experienced fewer side effects and speculated far less about the methods. The nature of the

uterus, rather than the qualities of blood, appeared to be the major common-sense reason for not choosing the IUD. An increase in menstruation appeared to be more acceptable than a decrease such as was caused by the hormonal methods. In the absence of signs of overexposure of the uterus to cold and ability to work hard without dislodging the IUD, women did not seek the removal of the IUD.

Although women usually chose the methods, husbands participated in speculation about the negative effects of the contraceptive methods, especially when they suffered the consequences. This sometimes lead to the discontinuation of a method by a woman against her better judgement. Speculation at home about DMPA and the pill was often related to the method's effects on menstruation; DMPA generally causes amenorrhea and the pill decreases the menstruation. The menstrual changes and subsequent accumulation, lead specifically to speculation about high blood and to a lesser extent, low blood and other chronic conditions such as tumors or cancer. Clinical practices contributed to these interpretations through the taking of blood pressure and screening for it prior to prescribing methods. The DMPA method was found to have a much more widespread effect on women's sexual interest than is documented in the literature and to cause coital dryness. The hormonal effect in turn had a negative impact on the couple's sexual life and relationship. Men however, were generally not willing to prevent the discomfort and health effects of contraceptive use with their wives by using condoms. The next chapter explores the strategies used by women to achieve their contraceptive goals given the their experiences, speculation, and the service provision circumstances in the region.

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 P80-97 and Trust Pill for P13-22. Difune 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 were 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 husbands either because they or their husbands worked for extended periods either in other locations in the Philippines or overseas, said they would stop using their methods when living apart from their husbands. They were vulnerable to pregnancy either because

[11] Because the study sample was chosen from clinic 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.

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

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

Table 7: Study Participants Discontinuing Before One Year of Use

DMPA	34	(N=44)
Pill	25	(N=56)
IUD	7	(N=28)
Condom	11	(N=11)

Rather than stopping contraception altogether women often switched between the various methods available at the government health clinic, pharmacies, and “natural” methods such as withdrawal and periodic abstinence. Some women switched methods frequently for a period of years and then use 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 one that 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 non-pregnancy related reasons.

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

5.0. 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 2-5 four years) of DMPA showed that they actually on average received just over two shots of DMPA per year rather than the prescribed 4. While 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 if 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."

5.1. 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 a 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 one time. These patterns account for some of the difficulty women had in recalling and explaining to interviewers exactly when they started and stopped a method of contraception.

5.4. 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, 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 husbands were 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 regarding 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 [DMPA] method 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 UTI or having malaria, because they were simply tired of taking it, or because they decided to try DMPA to gain weight.

5.5. 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 because of hypertension or because they wanted to have a normal menstruation. Another IUD user switched from 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 10 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. It is unclear the extent to which this strategy resulted in unwanted pregnancies. Another strategy involved switching to pills once becoming amenorrheic on DMPA. Once menstration 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.

Chapter 6

Client-Provider Interactions: Discussing Side Effects

This chapter examines some of the daily practices of family planning providers. Since the investigators did not spend time in the clinic on a daily basis and observe routine practices, the chapter focuses mostly on how providers and clients discuss the effects of the contraceptives during clinic interactions and what providers said about their own clinical practice. As discussed in the introduction, the client-provider interaction is a central focus for improving the quality of family planning services, although other aspects of service delivery, such as the constellation of methods provided, availability and access are also key aspects of quality over which the provider may have little control. (Chapter 5 touched on strategies used by women to increase the somewhat limited choice of family planning methods available at the government clinics, such as going to private clinics and pharmacies for different brands of oral contraceptive pills.) The decision to explore the client-provider interaction here over issues related to access was suggested not only by the DHS survey results, but also by the study data.

Rapid facility assessments conducted at the four rural health clinics serving the study communities showed that the clinics were at the time, adequately stocked, equipped, and staffed. The services provided are free, although a donation is requested. Thus, cost is generally not an issue. Because clinics were located in each barangay, women living in the study areas did not have to travel far to get to a facility. The reasons given by study participants living in these municipalities for discontinuing contraceptive methods when they did not wish to become pregnant were rarely related to access and supply issues but rather side effects and health concerns as the countrywide DHS found. Thus, it was decided to focus attention on the client-provider interaction rather than the other aspects of quality in family planning services.

A routine family planning client visit involves assessing why the woman came to the clinic, providing information on methods and follow-up, counseling on side effects, and other method use issues. Depending on the method a client is using, a routine visit might involve performing procedures such as taking the blood pressure, obtaining consent and conducting an IUD insertion, giving an injection, and/or providing supplies and referrals. As part of the first-time family planning client assessment, all of the midwives interviewed said that they ask women whether they are married and will only provide services if they say yes. For a new acceptor, midwives said they routinely ask whether their husband knows and agrees with the woman's use of the method requested.

Counseling on side effects occurs both prior to prescribing a contraceptive method and in follow-up visits.

The discussion below illustrates how women's health concerns and reported effects of pharmaceutical contraceptive methods offered through local government clinics are discussed in clinic interactions with midwives. This discussion should not be understood as an evaluation of clinic practice in

Quirino Province nor even the four study clinics. Rather it is intended to illustrate the difficulties encountered by those who counsel on pharmaceutical family planning methods in the Philippine context, the approaches that work and areas in need of more attention.

6.2. Pre-counseling on Side Effects

When prescribing a method of contraception to a woman for the first time, clinic procedures require counseling on the side effects of the method. When we asked midwives how they go about this type of counseling with a new pill acceptor, a midwife began with an explanation of how women come to stop using pills soon after starting:

> *"We have those who take the pill for one or two months, and they feel headache or dizziness, and they will stop taking the pill already."*

To address this, she said,

> *"We tell them that after three months OK, the body will adjust to the medication . . . [Before they start, we tell them] maybe they will have some discomfort like nausea because of taking the pill every day like that, or sometimes others will feel headache but that is normal. After three months, no more. It is just an adjustment. But for some women, it is no problem at all."*

During a clinic visit another midwife exemplified this type of counseling strategy with a woman returning for a re-supply of pills after her first month of use. When the woman told her that she was experiencing headaches she said,

> *"It is just the side effects. Within three months, we call it as the adjustment period, after that it will be gone. It is just normal to a new user to be adjusted with the method. What else have you felt?"*

The adjustment period is clear concept and taught through pre-counseling and follow-up counseling. The adjustment period is also described in detail in the UNFPA patient education literature on the pill, on hand in the clinics. Each woman we interviewed did understand the adjustment period when taking a new method, especially pills, although they spoke about this as an active process. For example, Josie said,

"At first, I felt like I was conceiving, and later, I learned to adapt to the method"

Pre-counseling on IUD side effects was done a bit differently by the following midwife. She said,

> *"With the IUD, you will have profuse menstruation. That is why the method is not good for an anemic person."*

Rather than saying “maybe” you will experience this side effect she says you will have this experience. Though her authoritative stand on the method makes her sound sure of herself, the information provided is not accurate from either a humoral or biomedical perspective and thus it will likely backfire at some point. It could cause a potential new user to reject the method outright, although it might have been a good option. Or if this woman with a new IUD inserted does not experience profuse menstruation, it could cause them to question the competence of the midwife.

6.3. Counseling on Weight Gain and Sexual Side Effects

Midwives asked women whether they were “becoming fat” with the method to assess the general acceptability of the method or whether the woman felt *hiyang* with the method. Conversely, clients answered with a statement about growing stout when asked about side effects. For example, one midwife asked,

> *“What are your experiences in using pills?”*

The client answered,

> *“None, I’m getting fat.”*

Though this is a general sign of *hiyang*, not all women desire to gain weight and this issue came up in the client-provider interactions. During a clinic visit for a DMPA injection the midwife told Rose that her blood pressure was 120/80 and that she weighed 69.6 kg. Rose commented,

> *“I’m becoming fat already.”*

To which the midwife responded,

> *“Better than you become thin. Any other problems?”*

The midwife did not return to the issue of weight later in the interview but rather dropped the subject altogether and thus bypassed an opportunity to explore the side effect. Another midwife did address the issue of weigh gain raised by the client illustrated in the following conversation:

> *MW: What are your problems in taking the pills?*
> *C: I become fat and sometimes I had spotting.*
> *MW: Maybe you need to control your diet.*
> *C: What other methods can you offer that I will not become fat?*
> *MW: IUD*
> *C: But I don’t want it. How about Depo?*
> *MW: The more you will become fat.*
> *C: I’ll just continue using the pills.*

Here the midwife does suggest the IUD when prompted by the client however the client says she does not want an IUD raising the issue of how much the midwife should discuss the client’s understandings about the IUD or just allow

the client to “choose” their own method. It is interesting that the suggestion of condom does not even arise in the encounter. It also demonstrates the bind that midwives are in because they do not have enough alternative methods to offer clients who do not tolerate, or do not prefer the two hormonal methods offered at government clinics.

Another midwife used the same tack as a midwife quoted earlier when a client raised her experience with sexual effects of the methods, avoidance. The following discussion took place between the midwife and a client receiving her third shot of DMPA.

> *MW: So this is your third shot? What do you feel since you stared using depo?*
> *C: I have a good appetite to eat, and sometimes I felt dizzy.*
> *MW: What else?*
> *C: If it's about our sexual contact with my husband, I have no urge and I never respond.*
> *MW: You don't have urge; you did not feel anything?*
> *C: Yes, ma'am, even my husband, he's not contented.*
> *MW: By the way, how many children do you have?*

Again, the midwife, who has more control over the topics discussed in the interview, dismissed the issue of sexual problems and moved on to other matters and did not return to the issue raised by the client during the interview.

It was interesting that though the midwives interviewed generally thought women would tell them about all the side effects, including sexual ones, some participants said that they would not discuss sex with the midwives because they would not be able to do anything about it. For example, during an interview, Becky explained why she stopped mentioning sexual side effects to the midwives in the clinic.

> *“If it is about sex, when I am using depo I experienced dryness and that is one of my problems also. It is very painful during our contact with my husband. I shared it with my fellow mothers when we had discussions . . . Yes, [I discussed the effect] with the midwife but she didn't explain it clearly. She just said it was normal. Even if I tell her that I felt really bad, she insists that it was normal, as if I'm just making an alibi.”*

Becky went so far as to find some literature on DMPA.

> *“I read an article about depo and sexual changes are not indicated there as a side effect. I didn't ask the midwife anymore because I'm sure, she will not give me a good explanation.”*

As discussed earlier sexual side effects occurred in 5% of the large sample of American women included in clinical trials of DMPA whereas in the current study many more than 5% reported these side effects. In fact the DMPA pamphlets by United Nations Family Planning Association (UNFPA) that are given out in the clinic also do not mention sexual changes as a side effect of the method. Rather the pamphlet discusses “changes in menstruation,” and

mentions “increased weight due to increased appetite,” “headaches,” and “flatulent or bloated feelings” as the side effects of the methods. [PFPP in cooperation with UNFPA]. From this she surmises that midwives, whose work is based on this type of information, will likely be of little help regarding her experiences with the methods.

In the group discussions following the round table presentation of the study results, several groups of midwives and BHWs were asked to answer the following questions generated from the findings on weight gain and sexual side effects:

> *How do you counsel women on sexual side effects and weight gain? Is there anything that you can do about them? Are weight gain and sexual side effects good reasons to switch methods?*

The majority of midwives, BHW and nurses present at the round table reported that these were not “real” but rather “psychological” side effects of the methods. One midwife went on to tell the large group that she counsels her female clients by telling them that it “is normal that women to lose interest in sex after a certain age,” and that this “natural” tendency, rather than the method, is causing their loss of interest in sex. She also added that they counsel women on better eating habits when they report too much weight gain. She concluded by saying that neither weight gain, nor sexual side effects were good reasons to switch to another method. When the facilitator asked the seven other members of the group if they agree they all shook their heads yes. This caused one 65-year-old female audience member to offer her own personal experience as testimony to demonstrate to the group that women do not necessarily loose interest in sex when they age. Midwives would benefit from training on the side effects identified in clinical trials and normal sexuality. Menstrual changes resulting from hormonal method use, also presented a huge counseling challenge for midwives.

6.5. Counseling on Menstrual Changes

Midwives are quite aware of this difference in their perspective on the body and that of the client although they would probably not articulate it as differences in understanding of the body. In fact it is a source of frustration for many of them. For example, one midwife said,

> *“They feel they are being poisoned if their period doesn’t come . . . they come to ask us is there anything we can use to cause the menstruation? I usually tell them that is injectable depo, it is natural that you will loose your period . . . I tell them [when they get the shot the first time], but they insist on telling that no, it is not safe that we will lose our period.”*

Midwives, many of whom come from similar backgrounds as the women they serve, draw on both humoral and biomedical knowledge in daily clinical practice. Some were not always managing changes in menstruation caused by the methods using a biomedical approach. This was evident in what clients said about how the midwife had advised them. For example, several said they were told by the midwife to stop using DMPA after a

prolonged period of amenorrhea. It is not clear whether this is done to gain the confidence of women in the community who understand the menstrual changes caused by the methods to be unhealthy or whether some midwives themselves may feel menstrual loss is not a healthy sign. Most midwives do counsel patients that the menstrual loss with DMPA is natural and harmless. Women work around the midwives when they disagree with her analysis of the situation which happened frequently among the study participants. For example, Mary said she decided that since she was one of the women who did not have menstruation with the method she just went in when she deemed it necessary:

> *"I used depo for around a year and stopped. For 6 months I had no depo injection and after that I had my menstruation again. When I had depo injection I did not menstruate, not even a single drop of blood that's why I informed the midwife and she told me that it's just the normal side effect of Depo. Side effects vary for each woman. Some women experience heavy flow for a month while others do not. That's why when I had amenorrhea I did not ask the midwife again…I just stopped last September to let my menstruation go back to normal…then I used Depo again."*

A classic approach for addressing differences in understandings related to the body or "lack of knowledge" as it is often referred to by clinicians, is to re-educate clients by instructing them on the biological body. One midwife used this technique in one client-provider interaction. In this instance, the client had decided to begin using DMPA, and the midwife went into greater biological detail while explaining the method and follow-up:

> *"In Depo, you have to come back every three months. Depo contains progesterone; it prevents ovulation. Some women experience dryness because it thickens the vaginal mucus and thus it prevents the sperm cell from entering the uterus. If there were no meeting of egg cells and sperm cell, there will be no pregnancy because there will be no ovulation. You know what ovulation is?"*

To this question, the client responded,

> *"Yes, I know."*

It is possible but not probable that the client holds the same ideas about ovulation as the midwife. At this point the midwife might have been wise to ask the client how ovulation works. However, she assumed the client had the same understanding of ovulation and went on to instruct the patient as follows:

> *"If you experience dizziness, severe headache, and bleeding, just come back here. But the side effects of depo are dizziness, mild headache and spotting."*

When the client asked for clarification on the central practical issue, changes in menstruation, the following exchange took place.

> *C: Is it normal if I experience spotting?*
> *MW: Yes.*
> *C: How come that is normal?*
> *MW: Because you never ovulate.*
> *C: Ok, ma'am.*

The midwife's answer is not particularly direct and the client probably does not understand what the midwife is talking about, but she does not push the issue. The clients' observations or thoughts on spotting and menstruation are not even discussed. The biological explanation works better when a model of the body is used and such models were available in the study clinics, although this approach has clear limitations. BHWs receive more education on family planning methods than the average woman in the province, though, as illustrated below, they do not necessarily incorporate ideas as a totality.

Barangay health workers

Interviews with barangay health workers as discussed in the last chapter, illustrate that they hold assumptions about the body that are closer to the average woman in Quirino province. For example, two excerpts from interviews with barangay health workers illustrate the ways that humoral and biomedical knowledge are combined during counseling of clients. When asked why one of her clients stopped taking DMPA to get her menstruation back, Georgia, a barangay health worker, said

> *"Its like the car; it needs a change of oil. In menstruation, it will cleanse the uterus. And it is better to have menstruation every month."*

Although she uses the classic biomedical machine-body analogy, the common-sense assumption is that a woman needs to have her menstruation every month to be healthy. Another barangay health worker, uses the lifespan of the average red blood cell to explain why women need to menstruate.

> *"Our blood has lifespan for 120 days after which it will be changed to another blood. The matured blood will go to the uterus as menstrual blood if it is not fertilized by sperm cells."*

Again, the biological information is combined with common sense derived from a different kind of body to rationalize why a woman needs to have her menstruation to be healthy. It was interesting that BHWs incorporated bits of what they learned about biology to rationalize why decreased menstruation was unhealthy and also why a slight increase in menstruation with the IUD could actually be healthy. While a few midwives may be recommending that clients stop using a method when they become amenorrheic it is likely that many of the BHWs hold this view and advise their neighbors as such.

6.6. Reading the Blood Pressure: High and Low Blood

Besides having a different common sense about the importance of menstruation for good health, clients and providers also held somewhat different assumptions about what constituted the illnesses of "high blood" and "low blood," and the potential effects of the contraceptive methods. Many Filipinos have experienced high blood and know the symptoms.

For example, when asked what the symptoms of high blood were, a midwife responded,

> *"Headache, neck pain, dizziness, and feeling nausea. Then we have to get the blood pressure. Usually, they can feel it [the blood pressure]."*

When asked,

> *"Do you get it yourself?"*

She said,

> *"Yes."*

This is commonly translated as hypertension, a biomedical-illness category. Cardiovascular disease is the leading cause of death in the Philippines. Hypertension is often called "the silent killer" because although hypertension threatens the health of an individual, many people do not know they have it because they cannot feel it. The question of whether a person can feel high blood pressure or not, gets varied responses from biomedical doctors. Some say yes, some say no, and some say that certain people who are more sensitive can feel it, and others do not. Women in Quirino can feel high blood and know what leads to it. High blood and low blood are opposites in humoral terms, so one has either an excess or a deficit but not both.

The client provider interactions and home interviews suggest that clients regularly read a different meaning into the blood pressure checks performed routinely by midwives in the clinic. For example, during a home interview, Josephine a barangay health worker, said,

> *"I always have my BP checked because I'm afraid. I am thinking that my BP is getting high, but it's just normal, 120/80."*

When asked whether she had experienced high blood pressure in the past, she responded,

> *"No, but when I was not yet using depo before, my BP was 90/60. When I used depo, my BP was good . . . 120/80."*

It is interesting that women found so much significance in the reading of the blood pressure, something of little interest to patients in many other clinical settings who are not diagnosed with hypertension. Not only does Josephine purposefully go to get her blood pressure checked at the clinic even though she has not been diagnosed with hypertension, but she also finds the minor differences in the readings significant to her health. Neither of the readings

would be considered significant from a clinical perspective since they are both "normal." The client, however, in this case, a barangay health worker, finds them significant and takes the slightly higher reading 120/80 to mean that her blood is more in balance perhaps, neither high nor low. And she takes the normal lower reading to mean that she was slightly low blood before she took DMPA. In other words, DMPA is improving her health to some degree. Georgia was not alone in her concern about blood pressure that was "too low."

6.61. Low Blood

A low blood pressure reading, understood either as one that is lower than 120/80 (the standard biomedical "normal" reading) or one that is lower than the last reading, was at times understood as a confirmation of low blood or anemia. Following from this, when one's blood pressure reading is a bit higher, it could be confirmation that the anemia has abated. For example, Elizabeth, a barangay health worker, explained that her anemia was indeed improved by using DMPA.

> *"Yes, I became fat [while taking DMPA] and besides what I know before is that I am anemic. But upon using DMPA my BP became normal."*

Clients expressed some doubt about whether their blood pressures were indeed normal in the clinic. In another client-midwife interview, when the midwife told the client,

> *"Your blood pressure is normal, 90/70."*

The client responded,

> *"Is it, midwife?"*

Appropriately, the midwife responded,

> "*Yes, as long as you don't feel dizzy and other negative feelings."*

Clarifying the symptoms of high blood versus low blood according to clients' reports, one physician said,

> *"They say headache and dizziness with anemia. [With high blood pressure], they say the symptoms are 'just the same, but the symptoms are more profound.' With anemia, one symptom is insomnia."*

The following exchange took place in an interview with a participant, Valentina.

> *V: My BP was 90/80. After taking the pills, my BP lowered to 70/60. That is why I can't sleep well at night.*
> *I: So your BP was low?*
> *V: Yes.*

I: Do you consider this as a side effect?
V: Yes, and until now I am experiencing it.
I: What did you do to remedy this?
V: I took multivitamins.

Ferrous sulfate tablets, sometimes referred to as "vitamins," were given to clients with low Hemoglobin readings or those who said they had profuse menstruation. Sometimes, clients reporting dizziness, thinness, or a poor appetite were also supplied with "vitamins." What is interesting is that giving ferrous sulfate, or vitamins is often thought to "increase the blood" or the blood pressure since these terms are used interchangeably. This came out in both home and clinic interviews. For example, a woman who wanted to continue pills but was being taken off the pill by the midwife had the following exchange:

MW: No. You cannot continue the pills because your BP is getting high.
C: Because the pills contain vitamins?

It is not clear that the midwife even heard the question, but she went on to prescribe another contraceptive method as a substitute for the pill. It is possible that if the patient thinks the "vitamins" in the packet of 28 pills (that is the 7 ferrous sulfate filler tablets) are causing the high blood pressure she might continue pills but avoid taking the ferrous sulfate tablets while possibly having hypertension.

One perceptive physician we spoke with is well aware of the translation problems related to high and low blood, anemia, and hypertension in the clinic, since patients with high blood pressure readings are referred to him for evaluation. He said,

"When the blood pressure is down, they think it's anemia already for them. But I keep telling them that diagnosis of anemia is based on hemoglobin. I've been telling them this. But some segment of clients are still confused about the high blood, anemia and/or the low blood . . . yes I've been telling them that they could have high blood and anemia at the same time because they are different things because if you have high blood, the pressure of your blood is very high, and then you have anemia because the hemoglobin is very low. So you can have them both. But then it's a contradiction for them. [They might say], 'how can you have anemia and high blood?' something like that. But I'm telling them they are different things."

The picture of a person with both anemia and hypertension hits the heart of the theoretical differences between the humoral and biomedical body and seems to be an excellent strategy to stimulate dialogue with clients on their differences in perspective.

Counseling on IUD

Suggesting the IUD is perhaps one way to avoid the problems related to menstrual changes resulting from the hormonal methods. This strategy was used by one midwife who reflected as follows.

> *"For some, they missed, they long for their menstruation. I usually advise IUD [to those women]."*

Of course the woman has to choose the method and of course there are several reasons already mentioned for why they do not choose it, one being that it is not very practical for working women and could cause the uterus unnecessary exposure to cold. One midwife asked the patient what she heard about the IUD. She responded,

> *"They were telling that if you carry heavy things, the IUD might come out.'*

She then went ahead and advised,

> *"No, it's not easy for the IUD to come out without any cause. To avoid any problem, better if you will not carry heavy things if you have your menstruation."*

When asked whether she would prescribe an IUD to a hard-working woman, a midwife reflected on the practice of telling women to avoid carrying heavy things when menstruating.

> *"They [those who do heavy work] can [get an IUD], yes. But we tell them that during menstruation, we tell them not to lift heavy things or it will be expelled . . . We tell them so that they will use the IUD. If you will not have problems don't carry heavy things during your menstruation so that you don't have problems. We also say things like that so they will use it . . . that is only our strategy . . . we also tell them, before injecting the IUD, we have to measure the depth. Then we can tell them it's not low."*

The utility of using this as a strategy is questionable. Honesty is often the best policy though allowing the client to talk about their own perspective and agreeing with their need to avoid heavy work while menstruating may leave more room for presenting a different perspective at another point in time.

These findings illustrate some of the difficulties encountered in the clinic when counseling on side effects of the contraceptive methods. To varying degrees, midwives and barangay health workers work with two kinds of knowledge about the body, health, and illness on the job—one humoral, the other biomedical. One is promoted through midwifery schooling, BHW training and supported by biomedical knowledge of the body and pharmaceuticals, and the other 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 sign of menstruation and its impact on health. Nor do they agree on the type or frequency of side effects of

pharmaceutical contraceptive methods. The provider's job often entails translating, interpreting, and negotiating these two kinds of knowledge and experience as they provide services to women.

Daily clinic practices such as conducting pre-counseling and follow-up counseling on the "adjustment period" are reflected in women's understandings of contraceptive methods, especially the pill. The use of a passive or an authoritative approach when advising on side effect sometimes caused women to stop going to the government clinic for family planning service or stop telling the midwives about particular effects of the methods such as the sexual side effects. The passive approach was exemplified in avoiding or ignoring women's reports of side effects deemed "psychological" by midwives, such as weight gain or loss of sexual interest. The authoritative approach involves being overly confident that one can predict the side effects that will be experienced by an individual client. Misunderstandings between providers and clients for example, about the meaning of high and low blood pressure and the reasons for prescribing or discontinuing methods, occur on a daily basis in the clinic. For example, practices such as screening women for high blood pressure before prescribing the hormonal methods and taking some women off the medication because of an increased blood pressure, may support women's hypothesis about the connection between high blood and high blood pressure. Midwives encounter situations where they do not have enough alternative methods to offer to women who are not able to tolerate or who do not like the effects of the methods available in the clinic. Offering a client a different method is the obvious option for addressing the weight gain, headache or sexual side effects of the methods for example. Midwives are not teaching clients about other methods for countering the sexual side effects of the methods for example, artificial lubrication that can make intercourse more comfortable. It is quite possible that the strong position taken by midwives on the "psychological" nature of the side effects reported by their clients, such as weight gain and sexual dysfunction, reflects their bicultural orientation. They may not be sure how to improvise explanations to patients using the logic of the biomedical body or they may simply feel the need to assert more authoritatively the biomedical position on menstruation in a context where women learn the opposite logic about health and menstruation at home.

Chapter 7

Conclusions and Recommendations

Culture moves down to the level of embodied experience and thus people in various socio-cultural contexts respond differently to pharmaceutical contraceptive methods. Though many of the same effects occur with the use of the pill, DMPA, IUD, and condoms throughout the world, such as menstrual irregularities and amenorrhea, they are felt, understood and acted on within particular socio-cultural circumstances. These contraceptive experiences of women in Quirino are profoundly influenced by their understandings and practices related to menstruation and fertility derived from humoral assumptions about the natural body, health and illness. Women's understanding of health and the suitability of a method to a woman in particular is not simply a matter of the safety and efficacy of the method (though this is important), but also whether it fits or even improves the quality of their lives including their relationships. This is reflected in the concept of *hiyang* or suitability.

The study participants experienced a particular pattern of effects with hormonal method use, including decreased or absent menstruation, headache, dizziness, and hot headedness. The pattern of effects correspond to humoral illnesses of "high" and "low blood" and women identified high and low blood as major health concerns related to using the hormonal methods. Women speculation about accumulating menstrual blood or pills gives rise to health concerns such as high blood, tumors and cancer that are voiced by women. Though women report fewer effects from the IUD, they often do not chose the method due to the "open" and "slippery" nature of the uterus during menstruation and the expectation that it might easily fall out, and, also perhaps because providers are hesitant to promote the method. Although the women who use IUDs are less likely to discontinue them, some experienced the pattern of effects, such as cramping, dizziness and abdominal pain that were attributed to hot-cold imbalance related to IUD use.

Though women usually choose their own contraceptive method, men influence the use of contraceptive methods through negotiation about the wives experiences of the effects of the methods. Sexual side effects, including lowered libido and coital dryness with DMPA use was much higher than one would expect given the findings of clinical trials on American women. These effects were sometimes disruptive to the couples' relationship for a period of time, though the majority of women stopped the method before one year of use. Men however, were generally not willing to prevent the discomfort and health effects of contraceptive use with their wives by using condoms. Providers and program planners also influenced women's contraceptive practices.

Cultural differences in the social construction of the humoral and biomedical body make the provider's job of communication and negotiation difficult. The key to competent "cross-cultural" care and counseling is to respect the diversity of experience among clients and community members including, their understandings related to the body, health and illness. In direct opposition to biomedical common sense and much of the family planning literature that promotes a decrease in menstruation as an "advantage" of

hormonal methods, an *increase* in menstruation is considered healthier by Qurino women than a *decrease* in menstruation. In this study, midwives and even public health nurses were either not completely informed about the biomedical side effects of the methods, or were taking a strong authoritative stance on the "realness" or conversely the fictitiousness or a "psychological-ness" of side effects to the detriment of their clients. For example, midwives tended to avoid discussing sexual and weight gain side effects with clients. This dynamic is also the result of midwives not having a sufficient variety of contraceptive methods to satisfy those clients who cannot tolerate any of the methods currently offered through the government clinics. That midwives are not treating side effects as real is quite troubling since good counseling on side effects of contraceptive methods is the linchpin of good quality family planning care.

While the majority of women seem to be getting through the adjustment period when using a new method, they are less likely to get the kind of information or be provided the choices they need to develop a biologically sound, long term strategy for preventing pregnancy. Rather, because of the differences between a biomedical perspective and humoral perspective of the body and the relations in the clinic, a significant number of women develop contraceptive strategies that expose them to the possibility of becoming pregnant long after an adjustment period has ended. For example women sometimes took pills only when their husbands were at home or used DMPA according to the body's menstrual response to the drug rather than every three months. Some women drop out of clinic service completely because their experience of side effects are not recognized as real and/or are ignored by midwives and/or because they do not offer an acceptable method of birth control. The women who used a method for an extended period of time tended to report no change, a slight decrease or an increase in menstruaion and few other accompanying side effects. This was true especially for pill and IUD long term users. The same sociocultural dynamics of the body, health and illness that affect the experience and use of contraception in Quirino are likely to arise in other provinces of the Philippines. This will likely be true to the extent that humoral logic, experiences and practices related to the body, health and illness and quality of care are similar.

This raises a central question: what are the better ways to discuss and manage differences in the social construction of the body, illness and medicine with clients? First of all, it appears that rather than teaching providers to value and making use of humoral knowledge in their clinical practice, nursing, midwifery and perhaps medical schools are attempting to train local knowledge out of providers. This approach provides little in the way of cross-cultural insight or tools that might assist providers in coping with the very real cross-cultural issues that arise in their daily in clinical practice. Thus the following two recommendations are made for training of providers.

- The training of midwives, doctors, and public health nurses should incorporate modules on alternative perspectives of the body, how to show respect for differences and negotiate treatment options. This type of module would include for example, discussions designed to sort out the differences between humoral and biological views of the body, health and illness and their significance in their personal and professional lives. The

training should also include practical skills for eliciting the client's perspective on the body and identifying areas where their perspectives conflict and ways to negotiate treatment options.

- Training of midwives should 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. In other words pharmaceuticals such as DMPA may have somewhat different effects in Filipinas as compared to Americans or Mexicans for example.

Secondly, providers function best when they have the resources they need to provide good service. Without a sufficient variety of methods, midwives may feel more pressure to try to convince women to use those methods that are available though they may not be well suited or even intolerable to them.

- Clients would likely benefit from having more choices of pharmaceutical methods offered through the government family planning clinics, such as diaphragm, several brands of OCPs, and emergency contraception. This might be partially accomplished through collaboration with local pharmacies that distribute several inexpensive alternatives to *Lo-gentrol*.
- Many clients use natural methods and would benefit from biologically based information on the use of natural methods, such as periodic abstinence and withdrawal.

Providers would also benefit from clinical standards references that are specifically geared to socio-cultural understandings and practices surrounding contraceptive use in their country or local area, and, from health education pamphlets that fully reflect the experiences of women using the methods.

- The *Family Planning Clinical Standards Manual* should be modified to include counseling on sexual side effects and weight gain, to reflect an underlying respect for women's views on the body and how to communicate this respect to the client through actions. And how to negotiate the two sets of assumptions (humoral and biomedical) about the body and health.
- The health education pamphlets produced by UNFPA and distributed through government family planning clinics should add decreased libido and coital dryness as possible side effects of the DMPA and OCP methods and what to do if a side effect is experienced.

Thirdly, regarding counseling, ignoring the humoral view of the body and treating women's and men's views as "misconceptions" clearly is not a respectful or culturally sensitive strategy. In addition, it is not enough to tell a woman that amenorrhea will likely occur after injections, or that menstruation will diminish with use of the pills and that this is normal, and leave it at that. An exclusively cognitive approach toward educating clients, such as using a biological model of the human body, does not work well with issues related to what people have physically experienced, for example that a sluggish or absent menstruation causes headaches, dizziness and hot headedness.

However, understanding of the cognitive differences in the humoral and biomedical body allows providers to identify areas of chronic miscommunication, such as in the meaning of high blood versus high blood pressure or that amenorrhea is not mean that one can not get pregnant and to address them in routine clinical practice and health education measures. Luckily, it is not necessary for a provider and client to agree on the theories of the body, or the cause of illness to find a solution that works for both parties. Both hubands and wives are involved and should be included in every aspect of health education efforts in this direction. Beyond this, good cross-cultural counseling skills in this setting would involve the following.

- Treat women's experiences as a fact: If a woman says she has an 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.
- Counseling on side effects is ongoing: Counseling on side effects prior to giving a method is important. However, perhaps more important, is talking to the client about the side effects after they begin a method and when they raise side effect concerns, or become not *hiyang* to the method after using it for several months. After the experience of unwanted side effects women are often more ready to listen and learn.
- Focus on manifest effects: Negotiation of method choice should take place around the manifest effects of the methods such as menstrual bleeding rather than according to which theories of the body are "correct."
- Switching is not a bad thing: Clients should be provided with the option of switching methods for side effects such as undesirable weight gain, sexual dysfunction, headaches, dizziness or amenorrhea. By doing so, clients will more likely switch methods under the guidance of providers rather than on their own or under advice from friends and relatives who may not be trained in family planning method use. Switching methods early on in one's reproductive career may facilitate finding the most suitable and reliable method for long term use.

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